

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3634

CERTIFICATE OF DEATH

036377

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS None given	
3. NAME OF DECEASED (Type or print) First Elmer Middle Batson Last Batson		4. DATE OF DEATH Month 4 Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1900
9. AGE (In years last birthday) yrs. 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Not given		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given		14. MOTHER'S MAIDEN NAME Not given	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Unk.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive heart disease DUE TO (c) Interval between onset and death	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/21/ , 19 55 , to 4/11 , 19 57 , that I last saw the deceased alive on 4/10 , 19 57 , and that death occurred at 11:15a , from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D.		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/11/57	
PHYSICIAN'S NAME (Type) L. Benedict, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 15/57	
22c. NAME OF CEMETERY OR CREMATORY Mt Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS 1463 N. Cayuse	
24a. REC'D BY REGISTRAR [Signature]		24b. REGISTRAR'S SIGNATURE [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

PLACE FOR SIGNATURE OF REGISTRAR		PLACE FOR SIGNATURE OF PHYSICIAN	
DATE OF DEATH		DATE OF SIGNATURE	
NAME OF DECEASED		NAME OF PHYSICIAN	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF DEATH	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 2

APR 16 1957

RECEIVED

3635

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A. COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FERNDALE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
c. LENGTH OF STAY IN 1b <u>3 weeks</u>				d. STREET ADDRESS <u>2210 ANNAPOLIS Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4 WILLOWDALE AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WALTER F. BEACH</u>				4. DATE OF DEATH <u>April 28 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 26-1899</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIL CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Industry</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY BEACH</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-07-2420</u>		17. INFORMANT <u>MRS. GLADYS E. BEACH</u> Address <u>2210 ANNAPOLIS Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan 1956</u> to <u>April 28, 1957</u> , that I last saw the deceased alive on <u>April 25, 1957</u> , and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Paul Schinfeld</u> M.D.							
PHYSICIAN'S NAME (Type) <u>PAUL Schinfeld</u> <u>2301 Annapolis Rd.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>MAY 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>GLEN-BURNIE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. P. Schinfeld</u> ADDRESS <u>3512 Frederick St.</u>				24a. REC'D BY REGISTRAR <u>4/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Schinfeld</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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RECEIVED
MAY 1 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3636
CERTIFICATE OF DEATH

03679

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u>		c. LENGTH OF STAY IN 1b <u>15 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hammonds Ferry Rd. @ Evelyln Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LORRETTA</u> Middle <u>MARY</u> Last <u>BOOTH</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1905</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Prather</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Cole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Peter G. Booth</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lt. Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with Metastasis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 mos.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 3, 1952</u> , to <u>April 30, 1957</u> , that I last saw the deceased alive on <u>April 19, 1957</u> , and that death occurred at <u>5:00A</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Milton Linthicum</u>		M.D. <u>4/30/57</u>	
PHYSICIAN'S NAME (Type) <u>C. Milton Linthicum</u>		<u>Linthicum Heights, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 3, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn RFD, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>R. H. Helwig</u>	

CERTIFICATE OF DEATH

7038

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 2

MAY 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03680

3637

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>18 Victor Parkway</i>		d. STREET ADDRESS <i>18 Victor Parkway</i>	
3. NAME OF DECEASED (Type or print) First <i>AMELIA</i> Middle <i>MARIE</i> Last <i>BOWLING</i>		4. DATE OF DEATH Month <i>APRIL</i> Day <i>9</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 4 1918</i>
9. AGE (In years last birthday) <i>38</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>WORCESTER MASS.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>ANTONY ROSSETTI</i>		14. MOTHER'S MAIDEN NAME <i>ROSALINA DiDOMENICA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>JOHN J.A. Bowling</i>		Address <i>#2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Spontaneous rupture of the spleen</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Spontaneous infection of spleen</i> DUE TO (c) <i>Metastatic tumor of spleen</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i> <i>14 days</i> <i>Unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3/28</i> , 19 <i>57</i> , to <i>4/9</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>3/30</i> , 19 <i>57</i> , and that death occurred at <i>9:30 A.</i> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>4/9/57</i>			
ACTUAL SIGNATURE <i>John L. Hildebrand</i> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>4-11-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>ST. MARY'S</i>	22d. LOCATION (City, town, or county) (State) <i>ANNAPOLIS MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>JOHN M. TAYLOR - SON</i>		ADDRESS <i>ANNAPOLIS MD.</i>	24a. REC'D BY REGISTRAR <i>4/10/57</i>
		24b. REGISTRAR'S SIGNATURE <i>U. D. Douch</i>	

100

BUREAU V. S.

APR 11 1957

RECEIVED

3638

CERTIFICATE OF DEATH

Reg. Dist. No.

261

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Hill	
c. LENGTH OF STAY IN 1b 4 years 4 mths		d. STREET ADDRESS 19x22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henrietta A. Bowser		4. DATE OF DEATH April 19 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown.
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland, U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Mattox		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Crownsville State Hospital, Crownsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Hypostatic DUE TO (b) Senility DUE TO (c) Arteriosclerosis, Cerebral & Generalized. 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1956 , to April 19 1957 , that I last saw the deceased alive on April 19th., 1957 , and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Crownsville, Md. DATE SIGNED April 19, 1957.			
ACTUAL SIGNATURE Ludwig Benedict, M.D.		M.D. Crownsville State Hospital, Crownsville, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR 24	
22c. NAME OF CEMETERY OR CREMATORY UPPER HILL		22d. LOCATION (City, town, or county) (State) UPPER HILL Somerset, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H Ward		ADDRESS Marion MP.	
24a. REC'D BY REGISTRAR DATE 4-25-57		24b. REGISTRAR'S SIGNATURE Mellie D. Payne	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		EDUCATION		OCCUPATION	
JAMES EARL RAY		APRIL 14, 1928		MALE		WHITE		HIGH SCHOOL		PUBLISHER	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
MOBILE, ALABAMA		APRIL 4, 1968		10:00 PM		HEART DISEASE		NATURAL		MOBILE, ALABAMA	
DISEASE OR INJURY		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT		HOSPITAL		PHYSICIAN	
CORONARY ARTERY DISEASE		NONE		NONE		NONE		MOBILE HOSPITAL		DR. JAMES H. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERGY		SIGNATURE OF JUDGE	

BUREAU V. 2

APR 29 1957

RECEIVED

3639

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piney Point 18X02</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>None given</u>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Rebecca</u> Last <u>Briscoe</u>		4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/7/95</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>— — —</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Not given</u>		14. MOTHER'S MAIDEN NAME <u>Not given</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>213-16-2063</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville State Hosp. Crownsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/14/57</u> , 19 <u>—</u> , to <u>4/15/57</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>4/15/</u> , 19 <u>57</u> , and that death occurred at <u>8:45 a.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>4/16/57</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's</u>		22d. LOCATION (City, town, or county) (State) <u>Valley Lee Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		ADDRESS <u>Fernandtown, Md.</u>	
24a. REC'D BY REGISTRAR <u>4/16/57</u>		24b. REGISTRAR'S SIGNATURE <u>Glenn D. Houser</u> <u>H. M. Joyner</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **4** hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3640 **CERTIFICATE OF DEATH**

03683

Reg. Dist. No. *28*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		<u>3601-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS <u>1701 N. Payson Street</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Helen</u> (First) <u>Brown</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>4</u> (Day) <u>17</u> (Year) <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>unknown</u>	9. AGE last birthday <u>38</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u> </u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Crownsville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1 <u>260X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage and Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Diabetis Mellitus</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized and Cerebral Arteriosclerosis</u>							
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, term, factory, OF INJURY street, office bldg., etc.) <u> </u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u> </u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>4-15-57</u>, 19 <u>57</u>, to <u>4-17</u>, 19 <u>57</u>, that I last saw the deceased alive on <u>4-17</u>, 19 <u>57</u>, and that death occurred at <u>1:55P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				M. D. <u>Crownsville, Maryland</u>		DATE SIGNED <u>4-18-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 23, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>St. Andrew</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
24. REC'D BY REGISTRAR <u>4-22-57</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>14637 Carey St</u>	

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. SEX

10. AGE

11. OCCUPATION

12. PLACE OF BIRTH

13. DATE OF DEATH

14. PLACE OF DEATH

15. CAUSE OF DEATH

16. SEX

17. AGE

18. OCCUPATION

19. PLACE OF BIRTH

20. DATE OF DEATH

21. PLACE OF DEATH

22. CAUSE OF DEATH

23. SEX

24. AGE

25. OCCUPATION

26. PLACE OF BIRTH

27. DATE OF DEATH

28. PLACE OF DEATH

29. CAUSE OF DEATH

30. SEX

31. AGE

32. OCCUPATION

33. PLACE OF BIRTH

34. DATE OF DEATH

35. PLACE OF DEATH

36. CAUSE OF DEATH

37. SEX

38. AGE

39. OCCUPATION

40. PLACE OF BIRTH

41. DATE OF DEATH

42. PLACE OF DEATH

43. CAUSE OF DEATH

44. SEX

45. AGE

46. OCCUPATION

47. PLACE OF BIRTH

48. DATE OF DEATH

49. PLACE OF DEATH

50. CAUSE OF DEATH

51. SEX

52. AGE

53. OCCUPATION

54. PLACE OF BIRTH

RECEIVED

BUREAU V. L.

APR 24 1957

RECEIVED

3633

CERTIFICATE OF DEATH

03676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover x 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box #115C Dorsey Rd.</u>				d. STREET ADDRESS <u>Box #115C Dorsey Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Evarias</u> Last <u>Barley</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 13</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army base</u>		11. BIRTHPLACE (State or foreign country) <u>Hamm, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Geseley Barley</u>				14. MOTHER'S MAIDEN NAME <u>Julia Short</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Daisy Parker</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 12</u> , 19 <u>48</u> , to <u>April 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>57</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>Rt 4 Box 112 Edinburg, Md.</u>			
DATE SIGNED <u>Apr 12 1957</u>							
PHYSICIAN'S NAME (Type) <u>[Signature]</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 15, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Rest</u>		22d. LOCATION (City, town, or county) (State) <u>Hanover, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>1631 David Hill Ave.</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MARTLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

APR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>2nd District</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2nd District</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SEVERN</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROUTE #1 Box 18</u> d. STREET ADDRESS <u>ROUTE #1 Box 18</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John E. Carmichael</u>		4. DATE OF DEATH <u>4 4 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 30 1928</u>
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months <u>28</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u>28</u> Min. <u>28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. ARMY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUNENBURG, VA.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY W. CARMICHAEL</u>		14. MOTHER'S MAIDEN NAME <u>JULIE KATHRYN FERGUSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>MRS. THELMA CARMICHAEL SEVERN, MD.</u>	
17. INFORMANT <u>MRS. THELMA CARMICHAEL SEVERN, MD.</u>		Address <u>MRS. THELMA CARMICHAEL SEVERN, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull - Crushing Injury Chest</u> DUE TO (b) <u>Fracture Pelvis - Gph fractures</u> DUE TO (c) <u>Fracture Cervical</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Auto accident</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:35 4/4/1957</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <u>Highway</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>APCO</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL APR. 5, 1957</u>		22b. DATE THEREOF <u>APR 5 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>JAMESTOWN CEM.</u>		22d. LOCATION (City, town, or county) <u>RICE</u> (State) <u>VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Jr.</u>		ADDRESS <u>1217 ST. PAUL ST.</u>	
24a. REC'D BY REGISTRAR <u>APR 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Giddings</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH	
7. PLACE OF DEATH		8. OCCUPATION		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF EXAMINER		12. DATE OF EXAMINATION	
13. HISTORY		14. PHYSICAL EXAMINATION		15. LABORATORY EXAMINATIONS		16. POSTMORTEM FINDINGS		17. OTHER FINDINGS		18. COMMENTS	
19. MEDICAL HISTORY		20. SOCIAL HISTORY		21. FAMILY HISTORY		22. PREVIOUS ILLNESSES		23. MEDICATIONS		24. ALLERGIC REACTIONS	
25. VITAL SIGNS		26. HEART		27. LUNGS		28. LIVER		29. SPLEEN		30. PANCREAS	
31. KIDNEYS		32. BLADDER		33. UTERUS		34. VAGINA		35. RECTUM		36. PROSTATE	
37. TESTES		38. THYROID		39. PARATHYROID		40. ADRENAL		41. PITUITARY		42. HYPOTHALAMUS	
43. BRAIN		44. SPINAL CORD		45. NERVOUS SYSTEM		46. EYES		47. EARS		48. NOSE	
49. MOUTH		50. THROAT		51. TRACHEA		52. BRONCHI		53. PULMONES		54. PERICARDIUM	
55. MYOCARDIUM		56. ENDOCARDIUM		57. VALVES		58. CORONARY ARTERIES		59. AORTA		60. PULMONARY ARTERY	
61. PULMONARY VEIN		62. VESICULAR BRONCHITIS		63. EMPHYSEMA		64. PNEUMONIA		65. TUBERCULOSIS		66. MALARIA	
67. SYPHILIS		68. GONORRHOEA		69. CHANCER		70. LYMPHOMAS		71. SARCOMAS		72. CARCINOMAS	
73. LEUKEMIA		74. LYMPHOMA		75. MYELOMA		76. OSTEOGENIC SARCOMA		77. CHONDROSARCOMA		78. FIBROSARCOMA	
79. GLIOMA		80. MENINGEAL SARCOMA		81. EMBRYOBLASTOMA		82. TERATOMA		83. DERMATOCARCINOMA		84. BASAL CELL CARCINOMA	
85. SQUAMOUS CELL CARCINOMA		86. ADENOCARCINOMA		87. TRANSITIONAL CELL CARCINOMA		88. ENDOMETRIAL CARCINOMA		89. OVARIAN CARCINOMA		90. UTERINE CARCINOMA	
91. CERVICAL CARCINOMA		92. VAGINAL CARCINOMA		93. RECTAL CARCINOMA		94. COLONIC CARCINOMA		95. GASTRIC CARCINOMA		96. PANCREATIC CARCINOMA	
97. BILIARY CARCINOMA		98. LIVER CARCINOMA		99. KIDNEY CARCINOMA		100. BLADDER CARCINOMA		101. PROSTATE CARCINOMA		102. TESTICULAR CARCINOMA	
103. OVARIAN CARCINOMA		104. UTERINE CARCINOMA		105. CERVICAL CARCINOMA		106. VAGINAL CARCINOMA		107. RECTAL CARCINOMA		108. COLONIC CARCINOMA	
109. GASTRIC CARCINOMA		110. PANCREATIC CARCINOMA		111. BILIARY CARCINOMA		112. LIVER CARCINOMA		113. KIDNEY CARCINOMA		114. BLADDER CARCINOMA	
115. PROSTATE CARCINOMA		116. TESTICULAR CARCINOMA		117. OVARIAN CARCINOMA		118. UTERINE CARCINOMA		119. CERVICAL CARCINOMA		120. VAGINAL CARCINOMA	

RECEIVED
 APR 8 1957
 BUREAU V. S.

WADO 10 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03685

3694

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>28 Cornhill St.</i>		d. STREET ADDRESS <i>28 Cornhill St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>GROVER LEROY CARRICK</i>		4. DATE OF DEATH Month Day Year <i>APRIL 18 1957</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT 3, 1911</i>
9. AGE (In years last birthday) <i>45</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SHEET METAL WORKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CONSTRUCTION</i>	
11. BIRTHPLACE (State or foreign country) <i>A. A. C. MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Grover C. Carrick</i>		14. MOTHER'S MAIDEN NAME <i>Mary Butler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Catherine R. Carrick (WIFE) #2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary tuberculosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>002X</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/17/57</i> , 19 <i>57</i> , to <i>4/18/57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4/17/57</i> , 19 <i>57</i> , and that death occurred at <i>2:00 P.M.</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <i>63 College Ave Annapolis Md 4/18/57</i>	
ACTUAL SIGNATURE <i>Frank M. Shipley</i>		M.D. <i>63 College Ave Annapolis Md</i>	
PHYSICIAN'S NAME (Type) <i>Frank M. Shipley</i>			
22a. BURIAL, CREMATION, REMAINS (Specify) <i>APRIL 20 1957</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>CEDAR BLUFF CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>ANNAPOLIS MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>JOHN M. TAYLOR</i>		ADDRESS <i>SONS ANNAPOLIS MD</i>	
24a. REC'D BY REGISTRAR <i>4/22/57</i>		DATE	
24b. REGISTRAR'S SIGNATURE <i>J. J. Donnell</i>			

BUREAU A

APR 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03686 24

3642

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH o. COUNTY <i>Ferndale Glen Burn P.O. MARYLAND</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland.</i> b. COUNTY <i>A. A. Co.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ferndale Md.</i>				c. LENGTH OF STAY IN 1b <i>6 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Ferndale.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>				d. STREET ADDRESS <i>1 Glen Burn P.O. Md</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Charley Roe Clark</i>				4. DATE OF DEATH Month Day Year <i>April 4 1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 30, 1883</i>	9. AGE (In years last birthday) <i>73 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm. Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>A. A. Co. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Samuel Vinton Clark</i>				14. MOTHER'S MAIDEN NAME <i>Sarah E. Hands -</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-28-0374-A</i>		17. INFORMANT <i>Mrs. Roe Clark</i>		Address <i>Same.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Valvular Disease of the Heart</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardio-Vascular Disease</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i> <i>10 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>50</i> , to <i>April 4</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>April 3</i> , 19 <i>57</i> , and that death occurred at <i>4</i> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James S. Bellingsha</i>				ADDRESS (Street, city or town, state) <i>108 Conbat Ave. Glen Burn Md</i>		DATE SIGNED <i>April 4, 1957</i>	
PHYSICIAN'S NAME (Type) <i>James S. Bellingsha MD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Funerary Co.</i>		22b. DATE THEREOF <i>April 6, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Friendship Cond.</i>		22d. LOCATION (City, town, or county) (State) <i>A. A. Co Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard V. Singleton</i>				ADDRESS <i>Glen Burn, Md</i>		24a. REC'D BY REGISTRAR DATE <i>April 6, 1957</i>	
						24b. REGISTRAR'S SIGNATURE <i>L. J. De Alba</i>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

3643

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF CLERGY		16. SIGNATURE OF OTHER		17. SIGNATURE OF OTHER		18. SIGNATURE OF OTHER		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER		61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	
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BUREAU V. S.

APR 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03687

3643

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Trunk House Rd.</u>		c. LENGTH OF STAY IN 1b <u>38 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park MD.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lelia</u> Middle <u>Clayton</u> Last <u>?</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11c. BIRTHPLACE (State or foreign country) <u>Anne Arundel County MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Zachary Johnson</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Lester M. White</u>		Address <u>Trunk House Rd S.P.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>—</u> , to <u>—</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>4-11-57</u> , 19 <u>—</u> , and that death occurred at <u>6:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. HAHN</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>4-11-57</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		<u>MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>4-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wormes Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hoppy Funeral Home</u>		ADDRESS <u>Annapolis MD</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Adley</u>	
DATE <u>15 1957</u>			

BUREAU V. S.

APR 15 1957

RECEIVED

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 3 mos. 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3Y01-4							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital						d. STREET ADDRESS 710 Woodyear Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)						First J hn		Middle Jefferson		Last Coleman		4. DATE OF DEATH Month 4 Day 5 Year 19 57	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/5/74		9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Benjamin Coleman						14. MOTHER'S MAIDEN NAME Martha Coleman							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address State Hospital Crownsville, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Nephrosclerosis DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular renal disease, gangrene of right foot,												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDER INVESTIGATION OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19									
				20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Crownsville, Md.		(County) Anne Arundel		(State) Md.	
21. I certify that I attended the deceased from 12/18 , 19 56 , to 4/5 , 19 57 ; that I last saw the deceased alive on 4/5 , 19 57 , and that death occurred at 8:50a. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lionel McHenry Mapp, M.D. Crownsville, Md. DATE SIGNED 4/5/57													
ACTUAL SIGNATURE Lionel McHenry Mapp, M.D.				PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/11/57				22b. DATE THEREOF 4/11/57		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) Annapolis Md		(State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Resett - Annapolis						ADDRESS Annapolis		24a. REC'D BY REGISTRAR APR 15 1957		24b. REGISTRAR'S SIGNATURE A. M. Joya			

1000

2360

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BUREAU A. S.

APR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3605 CERTIFICATE OF DEATH

Reg. Dist. No. 03689 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis - Letham</u>	
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>C.C. General Hosp</u>		d. STREET ADDRESS <u>C.C. General Hosp</u>	
4. NAME OF DECEASED (Type or print) <u>Baby Collins</u>		4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-4-57</u>
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Rosmary Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Rosie Brooks - Letham, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prematurity (20 wks gestation)</u> DUE TO 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/4/57</u> , 19 <u>57</u> , to <u>4/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/5</u> , 19 <u>57</u> , and that death occurred at <u>5:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Borsuck</u> M.D.		ADDRESS (Street, city or town, state) <u>Annapolis Md</u>	
PHYSICIAN'S NAME (Type) <u>S. Borsuck M.D.</u>		DATE SIGNED <u>4/9/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4-9-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Thos J. French</u>		24b. REGISTRAR'S SIGNATURE <u>Thos J. French</u>	
DATE <u>10 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063193XVO

CERTIFICATE OF DEATH

1. Name of Deceased: *John A. Smith*
2. Sex: *Male*
3. Age: *45*
4. Date of Birth: *1912*
5. Place of Birth: *St. Louis, Mo.*
6. Usual Residence: *1234 Main St., Baltimore, Md.*
7. Cause of Death: *Myocardial Infarction*
8. Date of Death: *April 10, 1957*
9. Time of Death: *10:15 AM*
10. Place of Death: *Home*
11. Physician: *Dr. J. H. Jones*
12. Medical Attendant: *Dr. J. H. Jones*
13. Burial Place: *Greenwood Cemetery, Baltimore, Md.*
14. Date of Burial: *April 12, 1957*
15. Name of Burial Place: *Greenwood Cemetery*
16. Name of Minister: *Rev. W. B. Brown*
17. Name of Officiant: *Rev. W. B. Brown*
18. Name of Witnesses: *Mr. & Mrs. J. A. Smith*
19. Name of Undertaker: *John's Funeral Home*
20. Name of Coroner: *John A. Smith*
21. Name of Registrar: *John A. Smith*
22. Name of Clerk: *John A. Smith*
23. Name of Nurse: *John A. Smith*
24. Name of Doctor: *John A. Smith*
25. Name of Pathologist: *John A. Smith*
26. Name of Anatomist: *John A. Smith*
27. Name of Embalmer: *John A. Smith*
28. Name of Cremator: *John A. Smith*
29. Name of Interment: *John A. Smith*
30. Name of Burial: *John A. Smith*

BUREAU V. S.

APR 10 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 13, 14 Film 0215 5-20-57 et
3606
CERTIFICATE OF DEATH

03690
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, Annapolis, Md.				d. STREET ADDRESS 90 Shipright Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine				4. DATE OF DEATH Month April Day 14 Year 1957			
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 July 1881		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 8 Days 29	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DECEASED Michael Murray				14. MOTHER'S MAIDEN NAME DECEASED Frances Wallace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address U.S. NAVAL HOSPITAL, Annapolis, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.1 GANGRENE, SMALL BOWEL & GENERALIZED ARTERIOSCLEROSIS, GENERAL PERITONITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 30 - 40 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 April , 19 57 , to 14 April , 19 57 , that I last saw the deceased alive on 14 April , 19 57 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, Annapolis, Md. DATE SIGNED 14 April 1957							
ACTUAL SIGNATURE L. A. Morales				M.D. U. S. Naval Hospital, Annapolis, Md.			
PHYSICIAN'S NAME (Type) L. A. MORALES, LCDR MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 14-17-57		22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEM.		22d. LOCATION (City, town, or county) (State) BALTO -	
23. FUNERAL DIRECTOR'S SIGNATURE Headfield's Son - Greenman				24a. REC'D BY REGISTRAR 22 1957		24b. REGISTRAR'S SIGNATURE Wm. J. French	

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		M		35		JAN 15 1922		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		CATHOLIC		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
APR 22 1957		NEW YORK		NEW YORK		NEW YORK		NEW YORK		APR 22 1957		NEW YORK		NEW YORK	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	

BUREAU V. 1

APR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 13, 14 Film 6215 5-10-57 et
3697
CERTIFICATE OF DEATH

03691
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MD.				c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach Park, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.				d. STREET ADDRESS Block 40		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HUGH Middle ERIC Last DANKER				4. DATE OF DEATH Month April Day 28 Year 19 57			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 January 1887	
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHC USN				10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) SWEDEN	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME DECEASED John Erickson Danker				14. MOTHER'S MAIDEN NAME DECEASED Matilda Danker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) 5/3/03-1945		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address U.S. Naval Hospital, Annapolis, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Rupture 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myocardial infarction DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 minutes 1 Week							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 25 April , 19 57 , to 28 April , 19 57 , that I last saw the deceased alive on 28 April , 19 57 , and that death occurred at 6:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED F. W. MEYER JR., CDR MC USN U.S. Naval Hospital, Annapolis, Md. 28 APRIL 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Arlington Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Jr.				ADDRESS 517-11th St. S.E.		24. REC'D BY REGISTRAR MAY 2 1957	
24b. REGISTRAR'S SIGNATURE Tom J. French							

BUREAU V. S.

MAY 2 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely permitted in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3645 CERTIFICATE OF DEATH

03607

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Pennsylvania</u> COUNTY <u>Fayette</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		LENGTH OF STAY (in this place) <u>3da 21 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Uniontown</u>		<u>75 X 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>RD #4, Box 453</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ALAN</u>		(Middle) <u>GERARD</u>		(Last) <u>DAUGHERTY</u>		(Date) <u>April 12 19 57</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>7 April 1957</u>	
9. AGE last birthday yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Soldier</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alvin Daugherty</u>				14. MOTHER'S MAIDEN NAME <u>Ginseppina Cassetti</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Father, 1404 Houghton Road, Glen Burnie, Maryland</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3 days 21 hrs	
776X IMMEDIATE CAUSE (A) <u>Prematurity</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7 Apr</u> 19<u>57</u>, to <u>12 Apr</u> 19<u>57</u>, that I last saw the deceased alive on <u>12 Apr</u> 19<u>57</u>, and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George Norman Schultz, MD.</u>				DATE SIGNED <u>12 Apr 57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR			
DATE <u>12 Apr 57</u>		R.H. MCGILL, CWO, USA		25. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK, INC.</u>		ADDRESS <u>1217 St. Paul Street</u>	
				LOCATION (City, town, or county) <u>Royal, Pennsylvania</u>			

2150371XVO

BUREAU V. S.

APR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03608

3646

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Fayette</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>3 day 9 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALVIN</u> Middle <u>GERALD</u> Last <u>DAUGHERTY</u>				4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 April 1957</u>		9. AGE (In years lost birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>9</u> Hours <u>9</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alvin Daugherty</u>				14. MOTHER'S MAIDEN NAME <u>Gineppina Cassetti</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Father, 1404 Houghton, Road, Glen Burnie, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> Prematurity <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 days 9 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 April 1957</u> , to <u>11 April 1957</u> , that I last saw the deceased alive on <u>11 April 1957</u> , and that death occurred at <u>9:16 PM</u> , from the causes and on the date stated above. DATE SIGNED <u>11 Apr 1957</u>							
ACTUAL SIGNATURE <u>Arnold D. Fiascone</u> M.D.				ADDRESS (Street, city or town, state) <u>A. 664 A H</u>			
PHYSICIAN'S NAME (Type) <u>ARNOLD D. FIASCONE, CAPT, MC.</u>				U. S. Army Hospital, Fort George G. Meade			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Royal, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cool Inc. 1217 St. Paul street</u> <u>Skirpan Funeral Home, Brownsville, Pa.</u>				24a. REC'D BY REGISTRAR <u>R.H. MCGILL, CWO, USA</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

2250372XVO

BUREAU A. S.

APR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03609

3647

CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>2mos. 16days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Not given</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not employed</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>— — —</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Not given</u>			14. MOTHER'S MAIDEN NAME <u>Frances Elizabeth Davis</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		(If yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT <u>Hospital Records</u> Address <u>Crownsville State Hospital</u> <u>Crownsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia, Decubitus in gluteal area, infected</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/18</u> , 19 <u>57</u> , to <u>4/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/2</u> , 19 <u>57</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>4/3/57</u>	
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STILL POND</u>		22d. LOCATION (City, town, or county) (State) <u>STILL POND Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>V. N. Kennedy</u>				ADDRESS <u>Still Pond Rd</u>		24a. REC'D BY REGISTRAR DATE <u>4/9/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
Clerk		High School		Married		Catholic		White		White		5' 10"		175	
Cause of Death		Immediate Cause		Intermediate Cause		Underlying Cause		Manner of Death		Place of Death		Date of Death		Time of Death	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Atherosclerosis		Natural		Home		JAN 5 1968		10:00 AM	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Zip		Physician's Phone		Physician's Fax	
[Signature]		JAMES EARL RAY		1234 Main St		Baltimore		MD		21201		(410) 555-1234		(410) 555-5678	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's City		Medical Examiner's State		Medical Examiner's Zip		Medical Examiner's Phone		Medical Examiner's Fax	
[Signature]		JOHN DOE		5678 Elm St		Baltimore		MD		21201		(410) 555-9876		(410) 555-4321	
Coroner's Signature		Coroner's Name		Coroner's Address		Coroner's City		Coroner's State		Coroner's Zip		Coroner's Phone		Coroner's Fax	
[Signature]		JANE SMITH		9101 Oak St		Baltimore		MD		21201		(410) 555-2109		(410) 555-8765	
Registrar's Signature		Registrar's Name		Registrar's Address		Registrar's City		Registrar's State		Registrar's Zip		Registrar's Phone		Registrar's Fax	
[Signature]		JOHN DOE		2345 Pine St		Baltimore		MD		21201		(410) 555-3456		(410) 555-7890	

RECEIVED
APR 5 1957
BUREAU V. B.

3648 **CERTIFICATE OF DEATH**Reg. Dist. No. 24**INSTRUCTIONS**

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>GLEEN BURNIE</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONV. HOME</u>				STREET ADDRESS (If rural give location) <u>600 E BIDDLE ST.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JAMES</u> <u>DORSEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar</u> <u>3</u> <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH		9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
358.3 IMMEDIATE CAUSE (A) <u>Epilepsy</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>MENTAL DETERIORATION</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 55</u> <u>1955</u> , to <u>Mar 3</u> <u>1957</u> , that I last saw the deceased alive on <u>Mar 30</u> <u>1957</u> , and that death occurred at <u>11:55 P</u> <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter T. ...</u>		ADDRESS (Street, city, town, state) <u>102 Balto. Annapolis Rd. N.E.</u>		DATE SIGNED <u>Mar. 4/57</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Embalmed</u>		DATE THEREOF <u>5.8.57</u>		NAME OF CEMETERY OR CREMATORY <u>of Md. Med. School</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Louis J. DeAlba</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>5/13/57</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Birth Date: May 1914

1. Name (Including Maiden Name of Female)

2. Place of Birth

3. Sex

4. Race

5. Date of Death

6. Time of Death

7. Cause of Death

8. Immediate Cause of Death

9. Duration of Illness

10. Place of Death

11. Name of Physician

12. Name of Attending Physician

13. Name of Hospital or Institution

14. Name of Burial Place

15. Name of Undertaker

16. Name of Coroner

17. Name of Registrar

18. Name of Medical Examiner

19. Name of Pathologist

20. Name of Anatomist

21. Name of Embalmer

22. Name of Funeral Home

23. Name of Cemetery

24. Name of Grave

25. Name of Interment

26. Name of Burial

27. Name of Cremation

28. Name of Disposition

BUREAU V. 1

MAY 18 1957

RECEIVED

SMITHSONIAN INSTITUTION

RECEIVED
MAY 18 1957
BUREAU V. 1
MAY 18 1957
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G213 4-9-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

036102

1. PLACE OF DEATH o. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <i>Solomon's Island Rd</i>	
3. NAME OF DECEASED (Type or print) First <i>Samuel</i> Middle <i>Dorsey</i> Last <i>Dorsey</i>		4. DATE OF DEATH Month <i>APRIL</i> Day <i>1</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1897 Mar 4</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR Months <i>4</i> Days <i>23</i> Hours <i></i> Min. <i></i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fireman, City water works</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Calvert Co</i>	
13. BIRTHPLACE (State or foreign country) <i>W.S.A.</i>		14. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. FATHER'S NAME <i>George A. Dorsey</i>		16. MOTHER'S MAIDEN NAME <i>(unknown)</i>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO. <i>Ms Violet Dorsey Parole Annapolis</i>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Insufficiency</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 y.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/15</i> , 19 <i>55</i> , to <i>2/1</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>2/1</i> , 19 <i>57</i> , and that death occurred at <i>5:00</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodore H. Johnson</i> M.D.		ADDRESS (Street, city or town, state) <i>37 Calvert Street</i> DATE SIGNED <i></i>	
PHYSICIAN'S NAME (Type) <i>Dr. THEODORE H. JOHNSON</i>		<i>Annapolis, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Apr 5/57</i>		22b. DATE THEREOF <i></i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i> ADDRESS <i>Annapolis, Md</i>		24a. REC'D BY REGISTRAR <i>APR 5 1957</i> 24b. REGISTRAR'S SIGNATURE <i>Thm. J. French</i>	

APR 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3649

CERTIFICATE OF DEATH

Reg. Dist. No.

03611

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1yr. 8mos. 19days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 2112 N. Howard Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Ella		First		Middle		Last Fortner	
4. DATE OF DEATH Month 4 Day 13 Year 19 57							
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/15/13	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Mississippi	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME James Fortner				14. MOTHER'S MAIDEN NAME Louvenia Fortner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		(If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records	
Address Crownsville State Hospital		Crownsville, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of the cerebral vessels DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Crownsville				(County)		(State)	
21. I certify that I attended the deceased from 7/25 , 19 55 , to 4/13 , 19 57 , that I last saw the deceased alive on 4/13 , 19 57 , and that death occurred at 10:35aM , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Benedict				M.D. Crownsville, Md.		DATE SIGNED 4/13/57	
PHYSICIAN'S NAME (Type) L. Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/18/57		22b. DATE THEREOF 4/18/57		22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital		22d. LOCATION (City, town, or county) (State) Crownsville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph H. Meng				ADDRESS M. D. Crownsville Md		24a. REC'D BY REGISTRAR DATE 4-18-57	
				24b. REGISTRAR'S SIGNATURE 11 m			

BUREAU A

APR 24 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY A.A. County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville R.F.D.1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A.A. General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry		First H.		Middle W.		Last Franks	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13, 1897	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH April 6 19 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Crownsville Hosp		11. BIRTHPLACE (State or foreign country) Milesburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Anna V. Franks, Crownsville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH instant. 4 yrs +							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/1/53 , 19____, to 4/6/57 , 19____, that I last saw the deceased alive on 4/1/57 , 19____, and that death occurred at 4:30 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Maurice F. Klawans M.D. 31 Southgate Ave Annapolis, Md PHYSICIAN'S NAME (Type) MAURICE F. KLAWANS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				ADDRESS AIR 10 1957		24b. REGISTRAR'S SIGNATURE Am. C. French	

VS A15 (4)
15M 9/55
15M 9/55

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1907

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY AND COUNTY	
AGE		SEX	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL ATTENDANT	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF MEDICAL ATTENDANT	
SIGNATURE OF WITNESSES		SIGNATURE OF REGISTRAR	

BUREAU V. S.

APR 10 1907

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3650

CERTIFICATE OF DEATH

Reg. Dist. No. 21

03613

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rolling Knolls		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Annapolis, Maryland		d. STREET ADDRESS Rolling Knolls	
3. NAME OF DECEASED (Type or print) First Middle Last RUDOLPH FRANZ		4. DATE OF DEATH Month Day Year APRIL 20, 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1875
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Taylor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-03-0398	
17. INFORMANT Mrs Helen Franz- Wife		Address same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 19 50 to Apr 20, 19 57 that I last saw the deceased alive on 4-20-19 57 , and that death occurred at 5 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Shaw Street, Annapolis, Md DATE SIGNED 4-22-57			
ACTUAL SIGNATURE James Martin		M.D.	
PHYSICIAN'S NAME (Type) James Martin MD		6 Shaw Street, Annapolis, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-57	
22c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR APR 23 1957		24b. REGISTRAR'S SIGNATURE John J. French	

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		April 23, 1957	
Age		Sex	
65		Male	
Race		Marital Status	
White		Married	
Place of Birth		Usual Residence	
Maryland		Maryland	
Cause of Death		Immediate Cause	
Heart Disease		Myocardial Infarction	
Duration of Illness		Period of Incubation	
10 days		None	
Place of Death		Attending Physician	
Home		Dr. J. Smith	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. 2

APR 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03614

3651

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE Same b. COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linstead, P.D. Severna Park				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 Riggs Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Susan Carol Gray				4. DATE OF DEATH Month April Day 8th. Year 19 57			
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/57	9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months 27	IF UNDER 24 HRS. Hours 27 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marvin Gray				14. MOTHER'S MAIDEN NAME Carol Plaeger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Marvin Gray (father) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital anomaly of the 754.4 DUE TO heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) heart DUE TO (c) Sudden						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4/8/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/9/57	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md			
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING + HIRTLEY			24a. REC'D BY REGISTRAR APR 10 1957	24b. REGISTRAR'S SIGNATURE L. G. Adkins			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File G215 5-10-57 et

03615

3610

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hospital</u>				d. STREET ADDRESS <u>TRACY'S XI</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>Griffin</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Approx. 72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GRAVE DIGGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Funeral</u>		11. BIRTHPLACE (State or foreign country) <u>AA Co MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>LOUIS Griffin</u>				14. MOTHER'S MAIDEN NAME <u>LIZA ANN Brooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Elsie Griffin</u> Address <u>603 Rosedale St Belt 16 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Generalized</u> DUE TO <u>1 day</u> (c) <u>1 yr.</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-26</u> , 1957, to <u>4-27</u> , 1957, that I last saw the deceased alive on <u>4-27</u> , 1957, and that death occurred at <u>4:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>AM</u> DATE SIGNED <u>4/30/57</u>							
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.				PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u> <u>6 SHAW ST. ANNAPOLIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>McKendree Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty Salisbury</u> ADDRESS <u>used</u>				24a. REC'D BY REGISTRAR DATE <u>5/2/57</u>		24b. REGISTRAR'S SIGNATURE <u>16</u>	

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **0361621**

3652

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>W.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Neck</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION, (If not in hospital, give street address) <u>Annapolis, Neck</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Henry</u> Last <u>Gross</u>				DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-6-1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handy Man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Henry Gross</u>				14. MOTHER'S MAIDEN NAME <u>Mary Augustus Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Grace Thorne Annapolis, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>916.0</u> DUE TO <u>Swims - Entire Body</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Sudden</u></p> </div> <div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u></p> </div> </div>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month <u>4</u> Day <u>10</u> Year <u>1957</u> o. m. <u>PM</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Annapolis</u>				20g. (County) <u>W.C.</u>		20h. (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis Neck</u>	
22d. LOCATION (City, town, or county) <u>Annapolis Neck, Md.</u>				22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Bense, Jr.</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>				DATE <u>APR 15 1957</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Handwritten text, likely a medical certificate or report, containing names and dates. The text is written in a cursive script and is partially obscured by the header and other markings. Visible fragments include "Henry B. ...", "1911-1912", and "1911-1912".

BUREAU V. S.

APR 15 1911

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 11, 12 FilmG214 4-29-57 et
3611
CERTIFICATE OF DEATH

Reg. Dist. No.

03617

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47x-3</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>157 PRINCE GEORGE ST.</u>		d. STREET ADDRESS <u>1501-27th ST. SE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALDINE HAGGARD</u>		4. DATE OF DEATH Month Day Year <u>Apr. 21 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 9,</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL PRESCOTT</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH ANDERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>MRS. VERA TADLOCK - WASH. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>central hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>gen arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 19 56</u> , to <u>Apr. 19 57</u> , that I last saw the deceased alive on <u>Apr. 20, 19 57</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Borssuck</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>57 Borssuck Ammargues St. 4/21/57</u>	
PHYSICIAN'S NAME (Type) <u>S. BORSSUCK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4-23-57</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Browningville</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee</u> ADDRESS <u>300-4th St NE WASH. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 23 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Funch</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		MARRIAGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CITY OF DEATH [Faint text]		COUNTY OF DEATH [Faint text]	
AGE OF DECEASED [Faint text]		SEX OF DECEASED [Faint text]	
RACE OF DECEASED [Faint text]		EDUCATION OF DECEASED [Faint text]	
OCCUPATION OF DECEASED [Faint text]		MANNER OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		IMMEDIATE CAUSE OF DEATH [Faint text]	
MEDICAL HISTORY [Faint text]		HISTORY OF PRESENT ILLNESS [Faint text]	
TREATMENT [Faint text]		POST-MORTEM EXAMINATION [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	

BUREAU V. 2

APR 23 1957

RECEIVED

3612

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Anne Arundel MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION 53 Franklin Street				d. STREET ADDRESS 53 Franklin Street			
3. NAME OF DECEASED (Type or print) First Middle Last CHRISTIAN HAM BROCK				4. DATE OF DEATH Month Day Year April 3, 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1872	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired fireman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-34-5458		17. INFORMANT Address Mrs Pauline Hambrock- Wife- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atherosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) gen. atherosclerosis DUE TO (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-24, 1957 to 4-3, 1957 , that I last saw the deceased alive on 4-2, 1957 , and that death occurred at 4:37 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edith Rodler M.D.				ADDRESS (Street, city or town, state) 45 Franklin Street, Annapolis, Maryland		DATE SIGNED 4-5-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-6-57		22c. NAME OF CEMETERY OR CREMATORY St. Anne's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR APR 8 1957		24b. REGISTRAR'S SIGNATURE John J. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased		Age		Sex		Race		Date of death		Place of death	
John Doe		45		Male		White		April 7, 1957		New York City	
Cause of death		Manner of death		Occupation		Education		Religion		Marital status	
Heart disease		Natural		Teacher		High School		Catholic		Married	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness		Signature of funeral director		Signature of undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

APR 8 1957

RECEIVED

3613

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Gen'l. Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month April Day 21 Year 19 57				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH April 4, 1905				9. AGE (In years last birthday) 52 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (clerk) Thos. Summerville				10b. KIND OF BUSINESS OR INDUSTRY Perkin, Illinois			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Berkely J. Hardy				14. MOTHER'S MAIDEN NAME Lena G. Bush			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 215 14 4752			
17. INFORMANT Mrs Hilda Hardy				Address Same As #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c) 2 days				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-18-57 19, to 4-21-57 , 1957, that I last saw the deceased alive on 4-21-57 , 1957, and that death occurred at 5:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 SHAW ST. ANNAPOLIS, MD. DATE SIGNED 4/22/57							
ACTUAL SIGNATURE James R. Martin M.D.				PHYSICIAN'S NAME (Type) JAMES R. MARTIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 24, 1957			
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.				22d. LOCATION (City, town, or county) (State) Brooklyn, RFD, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Richard V. Sigler				ADDRESS Glen Burnie, Md.			
24a. REC'D BY REGISTRAR Dr. H. W. French				24b. REGISTRAR'S SIGNATURE Dr. H. W. French			

MEDICAL CERTIFICATION

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED HARRY STANLEY		SEX Male		AGE 34		DATE OF BIRTH April 1, 1925		PLACE OF BIRTH St. Louis, Mo.	
MARRIAGE None		EDUCATION High School		OCCUPATION None		RELIGION None		RACE White	
DECEASED AT St. Louis, Mo.		PLACE OF DEATH St. Louis, Mo.		DATE OF DEATH April 1, 1957		TIME OF DEATH 10:00 AM		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		IMMEDIATE CAUSE Heart Disease		MEDICAL HISTORY None		TREATMENT None		POST-MORTEM None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF PHYSICIAN None		SIGNATURE OF CLERK None		SIGNATURE OF REGISTRAR None	
DATE April 1, 1957		TIME 10:00 AM		PLACE St. Louis, Mo.		COUNTY St. Louis		STATE Missouri	

BUREAU V. 2

APR 05 1957

RECEIVED

3614

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Annapolis</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Arundel General Hospt</i>		d. STREET ADDRESS <i>Passedena Md</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Michelle Hassard</i>		4. DATE OF DEATH Month Day Year <i>April 15 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>Oct 25 1956</i>
9. AGE (In years last birthday) yrs. Months Days Hours Min. <i>5 5</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Hassard</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>M Williams Passedena Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>bronchopneumonia</i> DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Mongolism, Congenital Heart Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/13</i> 19 <i>57</i> to <i>4/15</i> 19 <i>57</i> , that I last saw the deceased alive on <i>4/15</i> 19 <i>57</i> , and that death occurred at <i>11:30 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Nail H. Linsley</i> M.D.		ADDRESS (Street, city or town, state) <i>95 Catho Dul, Annapolis, Md</i>	
DATE SIGNED <i>4/16/57</i>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>April 18 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Morland Memorial Park</i>	22d. LOCATION (City, town, or county) (State) <i>Arundel, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>George L. Linsley</i>		ADDRESS <i>1030 Patterson Park Dr</i>	
24a. REC'D BY REGISTRAR <i>4/18/57</i>		24b. REGISTRAR'S SIGNATURE <i>Am. J. Linsley</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar	
13. Date of funeral		14. Place of funeral		15. Name of funeral home		16. Name of undertaker		17. Name of cemetery		18. Name of burial place		19. Name of interment place		20. Name of crematorium		21. Name of crematorium		22. Name of crematorium		23. Name of crematorium		24. Name of crematorium	
25. Name of informant		26. Relationship to deceased		27. Address of informant		28. Telephone number		29. Date of completion		30. Signature of informant		31. Signature of registrar		32. Signature of physician		33. Signature of crematorium		34. Signature of crematorium		35. Signature of crematorium		36. Signature of crematorium	

BUREAU V. 1

APR 22 1957

RECEIVED

THE STATE DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND
MAY 1 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3653

CERTIFICATE OF DEATH

Reg. Dist. No.

03621

1. PLACE OF DEATH a. COUNTY <u>ARDE BRUNDEL Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RT. 1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RT. 1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOX 311 SOLLEY Rd</u>		d. STREET ADDRESS <u>SOLLEY Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRIETTA</u> Middle <u>HAWKINS</u> Last <u></u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 15 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JACOB FRANKLIN</u>		14. MOTHER'S MAIDEN NAME <u>HENRIETTA CURRY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>EMMA HOWARD</u> Address <u>RT 1 Solley Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u> DUE TO (b) <u>Hypertensive Cardio-vascular disease</u> DUE TO (c) <u>not known</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 7, 1955</u> , to <u>April 25, 1957</u> , that I last saw the deceased alive on <u>April 24, 1957</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.M. McLaughlin</u> M.D.		ADDRESS (Street, city or town, state) <u>Parade C. Md.</u> DATE SIGNED <u>Apr. 25, 1957</u>	
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Marley Neck</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac L. Brown</u> ADDRESS <u>568 W. Montross St.</u>		24a. REC'D BY REGISTRAR DATE <u>4-18-57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. J. Feltner</u>			

BUREAU V. S.

APR 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3615

CERTIFICATE OF DEATH

Reg. Dist. No.

02622

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 292 West Street				d. STREET ADDRESS 292 West Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLTON ALYSIOUS HERRMANN				4. DATE OF DEATH Month Day Year APRIL 23, 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1902		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Herrmann				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I & II 215-01-3396		17. INFORMANT Address Mrs Catherine H. Herrmann- Wife - same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute myocardial infarction DUE TO (b) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Immediate 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March, 1957 to April 23, 1957 , that I last saw the deceased alive on April 5, 1957 , and that death occurred at 4:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John Hedeman M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 90 Cathedral Street, Annapolis, Md. April 25, 1957			
PHYSICIAN'S NAME (Type) John Hedeman MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-57		22c. NAME OF CEMETERY OR CREMATORY Annapolis National Cem.		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Md.		24. REGISTRAR'S SIGNATURE John J. Brennan	

CERTIFICATE OF DEATH

NAME OF DECEASED Anne Thompson		MARRIAGE Maryland		DATE OF DEATH April 27, 1957	
PLACE OF DEATH Baltimore, Md.		AGE 35		SEX Female	
RACE White		EDUCATION High School		OCCUPATION Housewife	
CITY OF DEATH Baltimore, Md.		STATE OF DEATH Maryland		COUNTY OF DEATH Baltimore	
DATE OF DEATH April 27, 1957		TIME OF DEATH 10:30 AM		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE OF DEATH No. 1234	
SIGNATURE OF DECEASED Anne Thompson		SIGNATURE OF WITNESS John Doe		SIGNATURE OF PHYSICIAN Dr. Smith	
DATE OF SIGNATURE April 27, 1957		DATE OF SIGNATURE April 27, 1957		DATE OF SIGNATURE April 27, 1957	
PLACE OF SIGNATURE Baltimore, Md.		PLACE OF SIGNATURE Baltimore, Md.		PLACE OF SIGNATURE Baltimore, Md.	
NAME OF PHYSICIAN Dr. Smith		NAME OF HOSPITAL St. Mary's Hospital		NAME OF NURSING HOME None	
ADDRESS OF PHYSICIAN 123 Main St.		ADDRESS OF HOSPITAL 456 Main St.		ADDRESS OF NURSING HOME None	
CITY OF PHYSICIAN Baltimore, Md.		CITY OF HOSPITAL Baltimore, Md.		CITY OF NURSING HOME None	
STATE OF PHYSICIAN Maryland		STATE OF HOSPITAL Maryland		STATE OF NURSING HOME None	
COUNTY OF PHYSICIAN Baltimore		COUNTY OF HOSPITAL Baltimore		COUNTY OF NURSING HOME None	
ZIP CODE 21201		ZIP CODE 21201		ZIP CODE None	
FEDERAL IDENTIFICATION NUMBER None		FEDERAL IDENTIFICATION NUMBER None		FEDERAL IDENTIFICATION NUMBER None	
MAYOR'S OFFICE None		MAYOR'S OFFICE None		MAYOR'S OFFICE None	
CITY CLERK None		CITY CLERK None		CITY CLERK None	
COUNTY CLERK None		COUNTY CLERK None		COUNTY CLERK None	
STATE CLERK None		STATE CLERK None		STATE CLERK None	
FEDERAL CLERK None		FEDERAL CLERK None		FEDERAL CLERK None	

BUREAU V. 2

APR 29 1957

RECEIVED

3616

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle also Last <u>WILLIAM HOLMES HOFFMAN JR. (William Hoffman)</u>		4. DATE OF DEATH Month Day Year <u>April 24 19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30, 1889</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>sewing machines</u>	11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William H. Hoffman Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Sally Ann Carr</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>214-05-0085</u>		17. INFORMANT Address <u>Mrs Mima Willis Hoffman- Wife- Same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>26 hr</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>19 56</u> to <u>4/24/57</u> , that I last saw the deceased alive on <u>4/24</u> 19 <u>57</u> , and that death occurred at <u>12:51 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>63 College Ave Annapolis, Md.</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Frank Shipley MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		24. REC'D BY REGISTRAR <u>APR 29 1957</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I 2 44 105 252

X

3

BUREAU V. 3

APR 29 1957

RECEIVED
APR 29 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3617

CERTIFICATE OF DEATH

Reg. Dist. No.

03624

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16 McKendree Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>S.</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John P. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Lipscomb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Robert D. Johnson</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>15 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 5, 1950</u> to <u>Apr. 7, 1957</u> , that I last saw the deceased alive on <u>Apr. 5, 1957</u> , and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Amos Garrett Blvd. Annapolis, Md.</u> DATE SIGNED <u>4/90/57</u>			
ACTUAL SIGNATURE <u>S. Borussuck</u> M.D.			
PHYSICIAN'S NAME (Type) <u>S. Borussuck, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-10-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor & Sons</u>		24. REC'D BY REGISTRAR <u>4/10/57</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>V. T. Trench</u>	

BUREAU V. S.

APR 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03625

3654

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>South Carolina</u> b. COUNTY <u>Richland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G Meade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Columbia 77x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>US Army Hospital</u>		d. STREET ADDRESS <u>3231 Murray St</u>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Holley</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 Dec 1878</u>
9. AGE (In years lost birthday) yrs. <u>78</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>No occupation</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>Aiken, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Sidney Holley</u>		14. MOTHER'S MAIDEN NAME <u>Miley Toole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Son, Lt Col Bruce H Johnson</u>		Address <u>Quarters 2686E MacArthur Rd, Ft Meade</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>9007</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>THROMBOPHLEBITIS</u> DUE TO (c) <u>FRACTURE LEFT HIP</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell off steps at Ft. Meade Hospital</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>12:00</u> P.M. <u>Noon</u> <u>3/29/57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ft. Meade Hospital Balto Md.</u>		20f. (City or town) (County) (State) <u>A.A.</u>	
21. I certify that I attended the deceased from <u>0800 14 Apr</u> , 19 <u>57</u> , to <u>0815 14 Apr</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 Apr</u> , 19 <u>57</u> , and that death occurred at <u>0300 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Phillip A Dibble</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Army Hospital</u> <u>14 Apr 57</u>	
PHYSICIAN'S NAME (Type) <u>Phillip A. Dibble, Capt, MC</u>		<u>Ft. George G Meade, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>APR 14, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BETHANY CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>AIKEN S. CAROLINA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook</u>		ADDRESS <u>1217 ST. PAUL ST</u>	
24a. REC'D BY REGISTRAR <u>RH McGILL</u>		24b. REGISTRAR'S SIGNATURE <u>EWOW3 USA</u>	

APR 16 1957

BUREAU A. S.

RECEIVED

036268

3655

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>407 Watty Court</u>	
3. NAME OF DECEASED (Type or print) First <u>Armsted</u> Middle <u>Jones</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labore</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balt. Transit Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Not given</u>		14. MOTHER'S MAIDEN NAME <u>Un Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT, Address <u>Crownsville State Hospital records Crownsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive Heart Failure</u> DUE TO (b) <u>none</u> DUE TO (c) <u>none</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 14</u> , 19 <u>57</u> , to <u>Apr. 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr. 11</u> , 19 <u>57</u> , and that death occurred at <u>6:13 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>4/11/57</u>	
PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		<u>Crownsville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>AA County Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Holstead</u> ADDRESS <u>918 Druid Hill Ave</u>		24a. REC'D BY REGISTRAR <u>APR 15 1957</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03627

3656

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Prince Edward</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>3 mo 11 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELI</u> Middle <u>—</u> Last <u>JORDAN, Jr.</u>		4. DATE OF DEATH Month <u>11</u> Day <u>April</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 December 1956</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		9b. AGE (In years last birthday) yrs. <u>3</u> Months <u>11</u> Days <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eli Jordan</u>		14. MOTHER'S MAIDEN NAME <u>Juanita Jane Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father, US Army Hospital, Ft G. G. Meade, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Anomalies</u> <u>759.9</u> DUE TO <u>Congenital Anomalies</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo 11 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>30 Dec 56</u> to <u>11 April 57</u> , that I last saw the deceased alive on <u>11 April 57</u> at <u>7:00 P.M.</u> and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>James G. White</u> M.D. <u>US Army Hospital, Ft G. G. Meade</u> <u>12 Apr 57</u>			
PHYSICIAN'S NAME (Type) <u>JAMES G. WHITE, CAPT, MC.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips</u>		24a. REC'D BY REGISTRAR DATE <u>12 Apr 57</u>	
ADDRESS <u>1808 N. Monmouth St.</u> <u>Arlington S. Phillips, Baltimore, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>R.H. MCGILL, CWO, USA</u>	

2050221XV4

3657 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>A. Carroll Co.</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Balt. City</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Alb. Bunnie P.O.</i>	LENGTH OF STAY (in this place) <i>6 mos</i>	CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Baltimore</i>	<i>3V01-4 ✓</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Forest Grove Road, Box 175, Rt 1</i>		STREET ADDRESS (If rural give location) <i>4942 Pennington Ave</i>	
3. NAME OF DECEASED: (First) <i>PETRONELLA</i> (Middle) <i>KWIZIKIEWICZ</i> (Last) <i>YEAGER</i>		4. DATE OF DEATH: <i>April 11 1957</i>	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Wid.</i>	8. DATE OF BIRTH: <i>April 15, 1882</i>
9. AGE last birthday: <i>74</i> yrs.		10. IF UNDER 1 YEAR: <i>Months</i> <i>Days</i> <i>Hours</i> <i>Min.</i>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>none</i>	
11. BIRTHPLACE (State or foreign country): <i>Lithuania</i>		12. CITIZEN OF WHAT COUNTRY? <i>alien</i>	
13. FATHER'S NAME: <i>unknown (deceased)</i>		14. MOTHER'S MAIDEN NAME: <i>unknown (deceased)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY No.: <i>no</i>	
17. INFORMANT & ADDRESS: <i>Reg. not 1380335</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
420.0 Immediate cause (a) <i>acute coronary occlusion</i>		<i>1 day</i>
Antecedent causes (s) (b) <i>arteriosclerotic Heart Disease</i>		<i>10 yrs</i>
(c) <i>none</i>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: <i>no</i> 19b. MAJOR FINDINGS OF OPERATION: <i>no</i>		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT (Specify) <i>none</i>	PLACE (Home, farm, factory, street, office bldg., etc.) <i>none</i>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>none</i>	INJURY OCCURRED White at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>none</i>
22. I hereby certify that I attended the deceased from <i>Oct. 1956</i> , to <i>present</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Nov. 18, 1956</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.		
SIGNATURE <i>H.F. Morayzok, M.D.</i>		DATE SIGNED <i>April 11, 1957</i>
23. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		DATE THEREOF <i>4-15-57</i>
NAME OF CEMETERY OR CREMATORY <i>Holy Cross</i>		LOCATION (City, town, or county) (State) <i>Baltimore</i>
DATE REC'D BY LOCAL REGISTRAR <i>4-16-57</i>	REGISTRAR'S SIGNATURE <i>L.J. Deakins</i>	24. FUNERAL DIRECTOR <i>St. Mary's Funeral Home</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 17 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03629

3618

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Calvert Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ANNIE BUSHROD First Middle Last Lane				4. DATE OF DEATH Month April Day 27 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH MARCH	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ANDREW LANE		14. MOTHER'S MAIDEN NAME SUSANNE BUTLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple crushing injuries of abdomen with massive peritoneal and retroperitoneal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 824x DUE TO (c) 824x							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Apparently fell from moving truck					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 4/27 p. m. 157		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF MAY 1957		22c. NAME OF CEMETERY OR CREMATORY BRAVE HILL		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur W. Hick ADDRESS 43 North 1st St ANNAPOLIS MD				24a. REC'D BY REGISTRAR 4/30/57		24b. REGISTRAR'S SIGNATURE J. J. [unclear]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the registrar prior to burial, cremation, or removal.

DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME

PLACE

CAUSE OF DEATH

MANNER OF DEATH

Medical examiner's findings of abdomen with
massive rupture of and retroperitoneal hemorrhage

Approximate time from moving truck

Approximate time from moving truck

BUREAU V. S.

MAY 3 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3619

CERTIFICATE OF DEATH

03630
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Hospital		e. STREET ADDRESS 3631 39th Street, N.W.	
3. NAME OF DECEASED (Type or print) Lester A. Lawrence		4. DATE OF DEATH April 10, 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/1897
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR: Months --- Days --- Hours --- Min. ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trust Officer		10b. KIND OF BUSINESS OR INDUSTRY Natl. Savings & Trust Co.-- Wash. D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Washington Lawrence		14. MOTHER'S MAIDEN NAME Amy Elberta Seville	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W.I		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hetty Green Lawrence-		Address 3631 39th St., N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anteroseptal myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute cholecystitis & cholelithiasis 3d			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19 57		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --- 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/30/1957 to 4/10/1957 , that I last saw the deceased alive on 4/10/1957 , 19 57 , and that death occurred at 10:55 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 63 College Ave. Annapolis, Md. DATE SIGNED 4/11/57			
ACTUAL SIGNATURE Frank M. Shipley		PHYSICIAN'S NAME (Type) Frank M. Shipley Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR APR 13 1957	
ADDRESS 2901 14th St. N.W. Washington, D.C.		24b. REGISTRAR'S SIGNATURE Wm. J. Luerch	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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APR 12 1957

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VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03631
28

3658

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4 d. STREET ADDRESS 618 Sarah Ann Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Lipscomb Last Lipscomb		4. DATE OF DEATH Month 4 Day 24 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given 9. AGE (In years last birthday) 65? yrs. IF UNDER 1 YEAR: Months — Days — Hours — Min. — IF UNDER 24 HRS. Months — Days — Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junkman		10b. KIND OF BUSINESS OR INDUSTRY — — —	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Barney Lipscomb		14. MOTHER'S MAIDEN NAME Carrie Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records Address Crownsville State Hospital, Crownsville, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure, arteriosclerotic DUE TO hypertensive cardiovascular disease (c) Remote CVA, Decubitus ulcers on buttock, dehydration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Remote CVA, Decubitus ulcers on buttock, dehydration INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/15/57 , 19 57 , to 4/24 , 19 57 , that I last saw the deceased alive on 4/24 , 19 57 , and that death occurred at 6:50 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/25/47			
ACTUAL SIGNATURE L. Benedict PHYSICIAN'S NAME (Type) L. Benedict, M. D.		M.D. Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/29/57	
22c. NAME OF CEMETERY OR CREMATORY St. Ambrose		22d. LOCATION (City, town, or county) (State) Balt. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. W. Cropper ADDRESS 512 (unwritten address)		24a. REC'D BY REGISTRAR APR 29 1957 24b. REGISTRAR'S SIGNATURE L. M. Jones	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68		4. DATE OF BIRTH 1889		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Retired		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. DECEASED AT Home		12. PLACE OF DEATH Baltimore, Md.		13. DATE OF DEATH April 29, 1957		14. TIME OF DEATH 10:15 AM		15. CAUSE OF DEATH Heart Disease	
16. DISEASE OR INJURY Coronary Artery Disease		17. PERIOD OF ILLNESS Several Months		18. PREVIOUS ILLNESS None		19. SURVIVAL OF SURVIVORS Yes		20. SIGNATURE OF DECEASED None	
21. SIGNATURE OF PHYSICIAN J. H. Harris		22. SIGNATURE OF WITNESSES None		23. SIGNATURE OF DECEASED None		24. SIGNATURE OF DECEASED None		25. SIGNATURE OF DECEASED None	

BUREAU V. 8

APR 29 1957

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

3659

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Md.		COUNTY AA	
CITY (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		LENGTH OF STAY (in this place) 9 months		CITY (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 307 Cathedral Place				STREET ADDRESS (If rural give location) 307 Cathedral Place			
3. NAME OF DECEASED (Type or Print) Edna Golden Maddeh				4. DATE OF DEATH 4 / 23 19 57			
5. SEX F		6. COLOR OR RACE W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH Sept. 27, 1897	
				9. AGE last birthday 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Oliver Hastings				14. MOTHER'S MAIDEN NAME Florence A. Hawkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Vernon R. Madden, Sr. same as 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
334X IMMEDIATE CAUSE (A) Apoplexy with Right HEMIPLEGIA				INTERVAL BETWEEN ONSET AND DEATH 12 Hours			
ANTECEDENT CAUSE(S) DUE TO Hypertension				7 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 20 19 46, to April 23, 19 57, that I last saw the deceased alive on April 23, 19 57, and that death occurred at 5:10 A.M. from the causes and on the date stated above.							
SIGNATURE Alfred Cole		M.D.		ADDRESS (Street, city, town, state) 136 S. HILTON ST. April 23, 1957		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/26/57		NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		LOCATION (City, town, or county) Glen Burnie, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Louis De Alba		25. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie		ADDRESS	
DATE 4/26/57							

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. DATE OF DEATH

14. PLACE OF DEATH

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. DATE OF DEATH

18. PLACE OF DEATH

19. SIGNATURE OF PHYSICIAN

20. SIGNATURE OF REGISTRAR

21. DATE OF DEATH

22. PLACE OF DEATH

23. SIGNATURE OF PHYSICIAN

24. SIGNATURE OF REGISTRAR

25. DATE OF DEATH

26. PLACE OF DEATH

27. SIGNATURE OF PHYSICIAN

28. SIGNATURE OF REGISTRAR

29. DATE OF DEATH

30. PLACE OF DEATH

31. SIGNATURE OF PHYSICIAN

32. SIGNATURE OF REGISTRAR

33. DATE OF DEATH

34. PLACE OF DEATH

35. SIGNATURE OF PHYSICIAN

36. SIGNATURE OF REGISTRAR

37. DATE OF DEATH

38. PLACE OF DEATH

39. SIGNATURE OF PHYSICIAN

40. SIGNATURE OF REGISTRAR

41. DATE OF DEATH

42. PLACE OF DEATH

43. SIGNATURE OF PHYSICIAN

44. SIGNATURE OF REGISTRAR

45. DATE OF DEATH

46. PLACE OF DEATH

47. SIGNATURE OF PHYSICIAN

48. SIGNATURE OF REGISTRAR

49. DATE OF DEATH

50. PLACE OF DEATH

51. SIGNATURE OF PHYSICIAN

52. SIGNATURE OF REGISTRAR

53. DATE OF DEATH

54. PLACE OF DEATH

55. SIGNATURE OF PHYSICIAN

56. SIGNATURE OF REGISTRAR

57. DATE OF DEATH

58. PLACE OF DEATH

59. SIGNATURE OF PHYSICIAN

60. SIGNATURE OF REGISTRAR

61. DATE OF DEATH

62. PLACE OF DEATH

63. SIGNATURE OF PHYSICIAN

64. SIGNATURE OF REGISTRAR

65. DATE OF DEATH

66. PLACE OF DEATH

67. SIGNATURE OF PHYSICIAN

68. SIGNATURE OF REGISTRAR

BUREAU V. 2

APR 26 1957

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03634

3660

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>			c. LENGTH OF STAY IN 1b <u>25 y.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In the woods, 50 feet from his home.</u>				d. STREET ADDRESS <u>Route 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Henry Mason</u>				4. DATE OF DEATH Month Day Year <u>April 9th. 19 57</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/18/1878</u>	
9. AGE (In years last birthday) <u>78 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Mason</u>				14. MOTHER'S MAIDEN NAME <u>Harriett A. Crobly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Coast Guard</u>		16. SOCIAL SECURITY NO. <u>067-10-3733</u>		17. INFORMANT Address <u>Mrs. Zelma Johnson, (Daughter)</u> <u>2332 Reistertown Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General Arteriosclerosis</u> (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/10/57</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holland Funeral Home</u>				ADDRESS <u>-1631 Druid Hill Ave.</u>		24a. REC'D BY REGISTRAR <u>APR 11 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Cara Lasley</u>				DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y. E.

APR 11 1957

RECEIVED

3661

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
c. LENGTH OF STAY IN 1b <u>19 Hours</u>		d. STREET ADDRESS <u>604 Trenton Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PETER E. MCGURN JR.</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 Nov 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired 1st Lt. Army</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter E. McGurn</u>		14. MOTHER'S MAIDEN NAME <u>Anna Welch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWII & Retired</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wife, Elsie I. McGurn</u>		Address <u>604 Trenton Road, Glen Burnie, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> <u>331X</u> DUE TO <u>Cerebrovascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>19 HRS.</u> <u>19 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ADENOCARCINOMA OF SPLENIC FLEXURE OF COLON WITH METASTASES TO REGIONAL LYMPH NODES AND LIVER</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>9 Apr</u> _____, 19 <u>57</u> , to <u>10 Apr</u> _____, 19 <u>57</u> , that I last saw the deceased alive on <u>10 Apr</u> _____, 19 <u>57</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Myron J. Myers</u> M.D. <u>USAN, FORT GEO. G. MEADE, MD. 10 April 57</u> PHYSICIAN'S NAME (Type) <u>MYRON J. MYERS, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>15 April 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl VA</u>	22d. LOCATION (City, town, or county) <u>Fort Meade VA</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton</u> ADDRESS <u>Singleton Funeral Home, Glen Burnie, Md</u>		24a. REC'D BY REGISTRAR <u>W. L. Saylor</u>	24b. REGISTRAR'S SIGNATURE <u>W. L. Saylor</u>
		DATE <u>10 Apr 57</u>	

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH BALTIMORE		NAME OF DECEASED _____	
SEX _____		AGE _____	
DATE OF DEATH _____		PLACE OF DEATH _____	
TIME OF DEATH _____		CAUSE OF DEATH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS _____		EDUCATION _____	
PREVIOUS ILLNESS _____		MEDICAL HISTORY _____	
PHYSICIAN'S SIGNATURE _____		CORONER'S SIGNATURE _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	

BUREAU V. S.

APR 15 1957

RECEIVED

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 1,2 5,6,7,10a, 11,12,13,14 FilmG214 4-29-57 et
 3620
 CERTIFICATE OF DEATH

03636

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. Gen. Hosp.</u>				d. STREET ADDRESS <u>Herald Harbor, Crownsville P. O.</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>H</u> Last <u>M. Ller</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>??</u>	9. AGE (In years last birthday) <u>Approx. 70</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 YEAR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gen. carcinomatosis (b-n)</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ca of head of pancreas -</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Mar 15, 1957</u> , to <u>Apr 18, 1957</u> , that I last saw the deceased alive on <u>Apr 18, 1957</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Annapolis Md</u> DATE SIGNED <u>4/19/57</u>							
ACTUAL SIGNATURE <u>S. Borssuck</u> M.D. <u>Ann Arbor Mich</u>				PHYSICIAN'S NAME (Type) <u>S. BORSSUCK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>4-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>G. of Md. Med. School</u>	
22d. LOCATION (City, town, or county)				22e. (State)		22f. (City, town, or county)	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>4-24-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. J. Linn</u>							

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

1957

BUREAU

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3621

CERTIFICATE OF DEATH

03637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home Wood Convalescent Home</u>		d. STREET ADDRESS <u>1426 West St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH BURNHAM MILLIKEN</u>		4. DATE OF DEATH Month Day Year <u>APRIL 16 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER RET</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOL</u>	
11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis A. Burnham</u>		14. MOTHER'S MAIDEN NAME <u>Martha E. Barnes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>DR. LYMAN F. MILLIKEN</u>		Address <u>ANNAPOLIS MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROSIS, GENERALIZED</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>72 HOURS</u> <u>6 YRS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/22, 1952</u> to <u>4/16, 1957</u> , that I last saw the deceased alive on <u>4/16, 1957</u> , and that death occurred at <u>1222 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward J. Beck</u>		ADDRESS (Street, city or town, state) <u>41 Southgate Ave, Annapolis</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD J. BECK MD.</u>		DATE SIGNED <u>4/16/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>4-18-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LAUREL HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SACONNA MAINE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR</u>		ADDRESS <u>SON ANNAPOLIS MD</u>	
24a. REC'D BY REGISTRAR <u>4/17/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>	

BUREAU A. 5

APR 22 1957

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **4 hours** after death. The bottom copy **may** be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

03638

3662

Reg. Dist. No. *24*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>ANNE ARUNDEL</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>AA</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Glen Burnie 5 YRS</i>		LENGTH OF STAY (in this place) <i>536 Munroe Circle</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Glen Burnie</i>		STREET ADDRESS (If rural give location) <i>536 Munroe Circle</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (Type or Print) <i>Alma Ethel Moss</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Apr. 18 1957</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M.</i>	8. DATE OF BIRTH <i>Sept 15 1924</i>	9. AGE last birthday <i>30 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>OWN Home</i>		11. BIRTHPLACE (State or foreign country) <i>WAGENER, S.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alvie W. Booth</i>				14. MOTHER'S MAIDEN NAME <i>Emma Dell Hydrick</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>248-36-1549</i>		17. INFORMANT & ADDRESS <i>Dale R. Moss, SAME AS R</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
19a. IMMEDIATE CAUSE (A) <i>190X METASTATIC MELANOMA - Left Leg</i>						INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19b. DATE OF OPERATION <i>10-25-56</i>		19c. MAJOR FINDINGS OF OPERATION <i>METASTATIC MELANOMA LEFT FEMORAL TRIANGLE</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>10-24, 1956</i>, to <i>4-18, 1957</i>, that I last saw the deceased alive on <i>4-18, 1957</i>, and that death occurred at <i>1:35</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>E. Proderick Shultz</i>		DATE THEREOF <i>4/20/57</i>		NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem.</i>		LOCATION (City, town, or county) (State) <i>Glen Burnie Md</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		24. REC'D BY REGISTRAR <i>L. J. Seallan</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping & Kirkley</i>		ADDRESS <i>Glen Burnie</i>	
DATE <i>APR 22 1957</i>							

[The page contains faint, illegible text and two dark, irregular marks.]

APR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2: 1. To be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3663

CERTIFICATE OF DEATH

03639

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 5 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Kane Road			
3. NAME OF DECEASED (Type or print) First Sally Middle Nolan Last Nolan				4. DATE OF DEATH Month 4 Day 21 Year 19 57			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given	9. AGE (In years last birthday) yrs. 76?	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joe Custus				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records			
				Address Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/21 , 19 56 , to 4/21 , 19 57 , that I last saw the deceased alive on 4/21 , 19 57 , and that death occurred at 6:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 4/22/57							
ACTUAL SIGNATURE L. Benedict				M.D. Crownsville, Maryland			
PHYSICIAN'S NAME (Type) L. Benedict							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/57		22c. NAME OF CEMETERY OR CREMATORY Long Green		22d. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frances A. Hensley				24a. REC'D BY REGISTRAR DATE 4/25/57		24b. REGISTRAR'S SIGNATURE Glathier Jayce	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAMES H. HARRIS		M		45		JAN 15 1912		BALTIMORE, MD		APR 10 1957		BALTIMORE, MD		HEART DISEASE	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		OCCUPATION		RELIGION		MANNER OF DEATH	
JAMES H. HARRIS		JANE H. HARRIS		MRS. JANE H. HARRIS		JAMES H. HARRIS JR.		HIGH SCHOOL		LABORER		METHODIST		NATURAL	
DATE OF INTERVIEW		BY		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	
APR 10 1957		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

RECEIVED
APR 25 1957
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3661 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03640
24

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>North Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>North Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			d. STREET ADDRESS <u>Forest Glen - Box 70</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marcia</u> Middle <u>June</u> Last <u>Novak</u>				4. DATE OF DEATH Month <u>4</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1929</u>		9. AGE (In years last birthday) <u>27</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typist</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Cement</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Lawrence Cross, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Hattie V. Allen</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. James E. Cross - 1009 E. Belvedere Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to strangulation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Strangled by man's neck tie</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u>4 15</u> p. m. <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Pasadena Anne Arundel Md.</u>	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , <u>Homicide</u> <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. S. Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>4-16-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickerson & Sons - Balto.</u>				24a. REC'D BY REGISTRAR DATE <u>4/18/57</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Decker</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Helen Anne Arnold	
Sex		Female	
Age		10 years	
Date of Death		April 22, 1957	
Place of Death		Home	
Cause of Death		Sudden	
Manner of Death		Natural	
Signature of Examiner		[Signature]	

As noted due to strangulation

Strangled by man's neck tie

BUREAU V. S.

APR 22 1957

RECEIVED

3665

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena RFD				c. LENGTH OF STAY IN 1b 11 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Water Oak Point				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena RFD				d. STREET ADDRESS Water Oak Point			
3. NAME OF DECEASED (Type or print) First WILSON Middle JOSEPH Last OLDOCK				4. DATE OF DEATH Month April Day 8 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 12/99	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner (ret)				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Long Island, N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andy A. Oldock				14. MOTHER'S MAIDEN NAME Sadie H. King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1 228-09-6658		17. INFORMANT Mrs. Ruby W. Oldock, Same As #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
INTERVAL BETWEEN ONSET AND DEATH 1 hour							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March , 19 52 to April 8 , 19 57 , that I last saw the deceased alive on April 8 , 19 57 , and that death occurred at 5:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. M. McLaughlin M.D.				ADDRESS (Street, city or town, state) Pasadena, Md.			
DATE SIGNED April 8, 1957							
PHYSICIAN'S NAME (Type) Randall M. McLaughlin, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 10/57		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard P. Smith				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE 4/8/57	
				24b. REGISTRAR'S SIGNATURE L. J. Macle			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

Name of Deceased		Age	
John Doe		45	
Sex		Male	
Race		White	
Date of Birth		Jan 1, 1877	
Place of Birth		New York City	
Cause of Death		Heart Disease	
Date of Death		Dec 15, 1922	
Place of Death		New York City	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. S.

APR 10 1923

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3666 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03642
26

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>None</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. LENGTH OF STAY IN 1b <u>2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 15 3401-4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laurel Rose Track</u>				d. STREET ADDRESS <u>5238-LINDEN-HEIGHTS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER-LEONARD-POULSEN</u>				4. DATE OF DEATH Month Day Year <u>APRIL-12 19 57</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/5/05</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 MRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter J. Poulsen</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-07-0084</u>		17. INFORMANT Address <u>Mrs. Geneva V. Poulsen-5238 Linden Heights Av</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faudert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>GUSTAVE-H. FAUDERT-M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/1/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/5/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) <u>Woodlawn, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Baltimore</u>				ADDRESS <u>17th Md</u>		24a. REC'D BY REGISTRAR DATE <u>4/3/57</u>	24b. REGISTRAR'S SIGNATURE <u>Ida Belle Smith</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		SINGLE		WIDOW		DIVORCED		UNKNOWN			

CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		SIGNATURE OF EXAMINER	
DISEASE		INJURY		POISONING		OTHER					

HISTORY OF DEATH		HISTORY OF DISEASE		HISTORY OF INJURY		HISTORY OF POISONING		HISTORY OF OTHER		HISTORY OF SIGNATURE	
PREVIOUS ILLNESS		PREVIOUS INJURY		PREVIOUS POISONING		PREVIOUS OTHER					

BUREAU V. S.

APR 4 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03643

CERTIFICATE OF DEATH

3667

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Md</i>		COUNTY <i>Anne Arundel</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Fair Haven</i>		<i>Life</i>		TOWN <i>Fair Haven</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>(First) Alice (Middle) Missouri (Last) Rexell</i>				<i>April 29 19 57</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 WKS.
<i>7</i>	<i>white</i>	<i>widow</i>	<i>June 3, 1872</i>	<i>84</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>Domestic</i>		<i>Maryland</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>John Doe</i>				<i>Annie Robinson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<i>---</i>		<i>William T. Rexell, Fair Haven, Maryland</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				<i>Cerebral Hemorrhage</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>High Blood pressure</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<i>3 hrs.</i>			
				<i>3 hrs.</i>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Mar</i> , 19 <i>57</i> , to <i>Apr</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Apr 29</i> , 19 <i>57</i> , and that death occurred at <i>7:30 P.</i> M., from the causes and on the date stated above.							
SIGNATURE <i>H. W. Ward</i>				DATE SIGNED <i>4/30/57</i>			
H. W. Ward M.D.				ADDRESS (Street, city, town, state) <i>Owings, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<i>Burial</i>		<i>5/1/57</i>		<i>Friendship Cem.</i>		<i>Friendship, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>4/30/57</i>		<i>H. W. Ward</i>		<i>Wm. A. Hutchins</i>		<i>Owings, Md.</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MAY 2 1957

RECEIVED

3668

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>107 Marley Neck Road</u>				d. STREET ADDRESS <u>107 Marley Neck Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>M.</u> Last <u>Riley</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 27, 1922</u>		9. AGE (In years last birthday) yrs. <u>34</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles W. Lynch</u>				14. MOTHER'S MAIDEN NAME <u>Lolita Larsh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>William T. Riley, 107 Marley Neck Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma of sigmoid</u> <u>153x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 23, 1953</u> , to <u>April 25, 1957</u> , that I last saw the deceased alive on <u>April 20, 1957</u> , and that death occurred at <u>11 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Bryant L. Jones, M.D. 104 Crain Highway 5</u> <u>4/26/57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>BRYANT L. JONES MD Glen Burnie MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc. 1217 S. Paul Street</u>				42a. REC'D BY REGISTRAR DATE <u>4/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Sealles</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. DATE OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3669

CERTIFICATE OF DEATH

03645

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1227 Church Street				d. STREET ADDRESS 1227 Church Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JENNIE E. Middle RIPPEON Last				4. DATE OF DEATH Month 4/9/57 Day Year 19			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/1/85		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Fogle				14. MOTHER'S MAIDEN NAME Ida E. White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family - Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiac Insufficiency DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-9 , 19 53 , to 4-9 , 19 57 , that I last saw the deceased alive on 4-9 , 19 57 , and that death occurred at 4:30 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3904 S. HANOVER ST. DATE SIGNED							
ACTUAL SIGNATURE Eugene Schmitzer M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) Eugene Schmitzer				3904 S. HANOVER ST.			
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 4/12/57		22c. NAME OF CEMETERY OR CREMATORY Linganore		22d. LOCATION (City, town, or county) (State) Unionville, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE McGully Funeral Homes - 130 E. Fort Ave.				24a. REC'D BY REGISTRAR APR 11 1957		24b. REGISTRAR'S SIGNATURE Adm. Schmitzer	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03646

3670

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle McKinley Last Rogers				4. DATE OF DEATH Month 4 Day 15 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/1/29	
9. AGE (In years last birthday) yrs. 27		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Littlesburg N.C.	
12. FATHER'S NAME Samuel Rogers Eaton				13. MOTHER'S MAIDEN NAME Helen Lillie Rogers			
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		15. SOCIAL SECURITY NO. Record		16. INFORMANT Hospital Records			
17. ADDRESS Crownsville State Hospital		18. CITY OR TOWN Crownsville, Md.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 955X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Status Thymico-lymphaticus DUE TO (c) Electro-shock treatment							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/8 , 19 57 , to 4/15 , 19 57 , that I last saw the deceased alive on 4/15 , 19 57 , and that death occurred at 8:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/15/57							
ACTUAL SIGNATURE [Signature]				M.D. Crownsville, Md.			
PHYSICIAN'S NAME (Type) L. Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR. 14 1957		22c. NAME OF CEMETERY OR CREMATORY National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				24a. REC'D BY REGISTRAR DATE 4-18-57		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

RECEIVED
BUREAU V. 4
 APR 22 1957

NAME OF DECEASED <i>William H. [illegible]</i>		DATE OF BIRTH <i>1892</i>	
PLACE OF BIRTH <i>[illegible]</i>		DATE OF DEATH <i>1957</i>	
OCCUPATION <i>[illegible]</i>		CAUSE OF DEATH <i>[illegible]</i>	
MANNER OF DEATH <i>[illegible]</i>		PLACE OF DEATH <i>[illegible]</i>	
SIGNATURE OF DECEASED <i>[illegible]</i>		SIGNATURE OF WITNESS <i>[illegible]</i>	
SIGNATURE OF PHYSICIAN <i>[illegible]</i>		SIGNATURE OF CLERK <i>[illegible]</i>	

3671

CERTIFICATE OF DEATH

Reg. Dist. No.

78

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 4yrs.7mos.14days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 307 Pine Street			
3. NAME OF DECEASED (Type or print) First William Middle Rolley Last Rolley				4. DATE OF DEATH Month 4 Day 3 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given		9. AGE (In years last birthday) 70?		IF UNDER 1 YEAR Months 70? Days 70? Hours 70? Min. 70?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry Rolley				14. MOTHER'S MAIDEN NAME Julia Rolley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Bleeding 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Liver Cirrhosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Erysipelas, Arteriosclerotic Heart Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/20 , 19 52 , to 4/3 , 19 57 , that I last saw the deceased alive on 4/2 , 19 57 , and that death occurred at 8:55a.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Benedict				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 4/3/57	
PHYSICIAN'S NAME (Type) L. Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4-5-57		22c. NAME OF CEMETERY OR CREMATORY St. Agnes Medical School		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. H. - Annapolis Md.				24a. REC'D BY REGISTRAR DATE 4/8/57		24b. REGISTRAR'S SIGNATURE R. M. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3622

CERTIFICATE OF DEATH

Reg. Dist. No.

03648

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>820 Chesapeake Ave</u>		d. STREET ADDRESS <u>820 Chesapeake Ave</u>	
3. NAME OF DECEASED (Type or print) <u>AGNES</u> First <u>LEE</u> Middle <u>RUSSELL</u> Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22 1901</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>CAMBRIDGE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS S. PRICE</u>		14. MOTHER'S MAIDEN NAME <u>EDNA E. PRICE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>JESSE C. RUSSELL</u> Address <u>(SAME AS 2)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Carcinoma Ovary</u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 26</u> , 19 <u>56</u> , to <u>April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>57</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>E. Linhardt</u> M.D. <u>Annapolis, Maryland</u> <u>4/18/57</u> PHYSICIAN'S NAME (Type) <u>E. Linhardt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>APR. 20, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. ANNE'S CEM.</u>		22d. LOCATION (City, town, or county) <u>ANNAPOLIS</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>4/22/57</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		24c. REGISTRAR'S SIGNATURE <u> </u>	

18804

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH			
JAMES M. JONES		35		M		W		1880		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK			
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
APR 22 1967		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		APR 22 1967		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH	
HEART DISEASE		NATURAL		NEW YORK		NEW YORK		NEW YORK		NEW YORK		HEART DISEASE		NATURAL		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
APR 22 1967		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		APR 22 1967		NEW YORK		NEW YORK		NEW YORK		NEW YORK	

BUREAU V. S.

APR 23 1967

RECEIVED

3672

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Willow St.</i>		d. STREET ADDRESS <i>Willow St</i>	
3. NAME OF DECEASED (Type or print) First <i>Richard</i> Middle <i>Clyde</i> Last <i>Russell</i>		4. DATE OF DEATH Month <i>4</i> Day <i>14</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-24-57</i>
9. AGE (In years last birthday) <i>2</i> yrs.		IF UNDER 1 YEAR Months <i>2</i> Days <i>2</i>	IF UNDER 24 HRS. Hours <i>2</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William Clyde Russell</i>	
14. MOTHER'S MAIDEN NAME <i>Lydia Laure</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Wm Clyde Russell</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> DUE TO <i>9240</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Sudden</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Asphyxia by bed covers</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Asphyxia by bed covers</i>	
20c. TIME OF INJURY Month, Day, Year <i>19</i> Hour <i>02</i> o. m. <i>02</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>4/14/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-16-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Heel Crest</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>	
24a. REC'D BY REGISTRAR <i>4/17/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. D. Russell</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 22 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03650

Reg. Dist. No. 74

3673

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u> c. LENGTH OF STAY IN 1b <u>1 month.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Theresa Barbara Sauerwald</u> 4. DATE OF DEATH Month Day Year <u>April 15th. 1957</u>				5. SEX <u>F.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>11/7/82 1881</u> 9. AGE (In years by birthday) yrs. <u>75</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (blind)</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown.</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>No</u> 17. INFORMANT Address <u>Leroy M. Sauerwald (Son).</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO (b) <u>Genral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Complete blindness.</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u> <u>All life</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/15/57</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Brooklyn, RFD, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Glen Burnie, Md.</u>					
24a. REC'D BY REGISTRAR DATE <u>4/17/1957</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Haslop</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: For: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 17 1957

RECEIVED

3674 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Linthicum c. LENGTH OF STAY IN 1b 30 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 309 Hammonds Ferry Rd.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 25 3401-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Baltimore 25 d. STREET ADDRESS 4918 Pennington Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Grace Schneeberger				4. DATE OF DEATH Month Day Year April 20th. 1957			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/89	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Glass				14. MOTHER'S MAIDEN NAME Unknown.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-07-9267		17. INFORMANT Address Mr. Ernest Schneeberger (son.)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) 4201 (c) 4201 DUE TO stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore		(County) Calvert	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/21/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 23-1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) A.A. County Md.				
23. FUNERAL DIRECTOR'S SIGNATURE George R. Schwab			ADDRESS 2101 Frederick Ave		24a. REC'D BY REGISTRAR APR 24 '57	24b. REGISTRAR'S SIGNATURE Rev. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

012-01-1017

Township

BUREAU V. B.

APR 24 1957

RECEIVED

Received at Baltimore
Bureau of Health Statistics

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3675

CERTIFICATE OF DEATH

Reg. Dist. No.

03652
20

1. PLACE OF DEATH a. COUNTY <u>Ann Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudley, West River</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>11 Sudley, West River</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Wayson Seibel</u>		4. DATE OF DEATH Month Day Year <u>April 28 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 March '13</u>
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland, USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES EDWARD</u>		14. MOTHER'S MAIDEN NAME <u>CALPURNIA STALLINGS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Frank R. Carter - Daughter - same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auricular Fibrillation.</u> (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>4 months</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypotension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1956</u> , to <u>April 1957</u> , that I last saw the deceased alive on <u>28 April 1957</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. D. Hendricks</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Shady Side, Maryland 4/29/57</u>	
PHYSICIAN'S NAME (Type) <u>F. D. Hendricks</u>		<u>Shady Side, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 1, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Mt Zion, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DATE 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Smith</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

22

3676

1. PLACE OF DEATH o. COUNTY <u>A.A. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt.#2, Severn</u>				d. STREET ADDRESS <u>Route #2 Camp Meade Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Shelton</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1870</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman (ret'd)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City Hosp.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Shelton</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				17. INFORMANT Address <u>Mrs. Evelyn E. Shelton, Rt.#2, Box 14, Severn, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe tetanus</u> DUE TO (c) <u>Cerebral thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 yr</u> <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 15, 1957</u> , to <u>April 14, 1957</u> , that I last saw the deceased alive on <u>April 11, 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. J. [Signature]</u>				DATE SIGNED <u>4-16-57</u>			
PHYSICIAN'S NAME (Type) <u>ODENTON, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>4-16-57</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Shulps</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 17 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03654

CERTIFICATE OF DEATH

Reg. Dist. No.

76

3677

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN IB 1yr. 2mos. 11days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH Month 4 Day 1 Year 19 57				5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Unknown 4/14/1898				9. AGE (In years last birthday) 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not given COOK				10b. KIND OF BUSINESS OR INDUSTRY Unknown			
11. BIRTHPLACE (State or foreign country) Brownsville Virginia				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Witt Shultz				14. MOTHER'S MAIDEN NAME Patience (Patricia) Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unk.			
17. INFORMANT Hospital Records				Address Crownsville State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal cirrhosis of the liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic duodenal ulcers, portal thrombosis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/21 , 19 56 , to 4/1 , 19 57 , that I last saw the deceased alive on 4/1 , 19 57 , and that death occurred at 3:30a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/1/57							
ACTUAL SIGNATURE [Signature] M.D. [Signature]							
PHYSICIAN'S NAME (Type) L. Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/57		22c. NAME OF CEMETERY OR CREMATORY Balto National Cem		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Hulstons				24a. REC'D BY REGISTRAR DATE 4/2/57			
ADDRESS 918 Daniel Hill Ave				24b. REGISTRAR'S SIGNATURE X M. Joyce			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 11, 12, 13, 14 Film 215 5-20-57 et
 3623
 CERTIFICATE OF DEATH

03655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ad General</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>BERNARD</i> Middle <i>SMITH</i> Last <i>SMITH</i>				4. DATE OF DEATH Month <i>4</i> Day <i>5</i> Year <i>1957</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <i>97</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>?</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Artemia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>							INTERVAL BETWEEN ONSET AND DEATH <i>hours & mins</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-15-57</i> 19 to <i>4-15-57</i> 19, that I last saw the deceased alive on <i>4-15-57</i> 19, and that death occurred at <i>12</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A.T. Allen</i> M.D.				ADDRESS (Street, city or town, state) <i>62 Catherines St</i> DATE SIGNED <i>4-10-57</i>			
PHYSICIAN'S NAME (Type) <i>A.T. ALLEN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>4-11-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Calver Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <i>4-12-57</i>	
						24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>	

CERTIFICATE OF DEATH

8033

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		MALE		39		JAN 5 1928		MOBILE, ALABAMA		LABORER		SINGLE		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
APR 4 1968		11:00 PM		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		[Signature]		[Signature]		[Signature]	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. FILING OFFICE		22. FILING DATE		23. FILING TIME		24. FILING OFFICER	
MEMPHIS		MEMPHIS		TENNESSEE		38103		HEALTH DEPT.		APR 10 1968		10:00 AM		[Signature]	

BUREAU V. R.

APR 15 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3678 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03656

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>a a</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>20 Falesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES BENJAMIN SMITH</u>				4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/83</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Bldg.</u>		11. BIRTHPLACE (State or foreign country) <u>Fair Haven Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis A Smith</u>				14. MOTHER'S MAIDEN NAME <u>Angie E. Wilkerson, Lulu</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 18 7171</u>		17. INFORMANT Address <u>CE Wilbur Smith, Falesville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardio-vascular disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1941, to <u>Apr. 10</u> , 1957, that I last saw the deceased alive on <u>April 5</u> , 1957, and that death occurred at <u>10:20 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Borssuck</u>				ADDRESS (Street, city or town, state) <u>Amos Garrett Ryld., Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.</u>				DATE SIGNED <u>4/12/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St James</u>		22d. LOCATION (City, town, or county) (State) <u>Tracy's Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty Galesville Md</u>				24a. REC'D BY REGISTRAR DATE <u>4/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. ...</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03657

3679 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shady Side</u>		LENGTH OF STAY (in this place) <u>Life?</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shady Side</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>(West Shady Side)</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Samuel Percy Smith</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>4th 22nd 19⁵⁷</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>April 11, 1880</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Shady Side Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Smith</u>				14. MOTHER'S MAIDEN NAME <u>Catherine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>215 14 5229</u>		17. INFORMANT & ADDRESS <u>EMMA King Smith, Shady Side Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4221 IMMEDIATE CAUSE (A) <u>Probable Ventricular Fibrillation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute myocardial insufficiency</u>				<u>One hour</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Chronic Congestive Failure</u>				<u>Two years</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Advances Arteriosclerosis</u>				<u>two plus years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 19 53</u> , to <u>22 Apr 19 57</u> , that I last saw the deceased alive on <u>4-15</u> , 19 <u>57</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.							
SIGNATURE <u>F. D. Hendricks</u> M.D.				ADDRESS (Street, city, town, state) <u>Shady Side, Maryland</u> DATE SIGNED <u>4/24/57</u> (Signed)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/24/57</u>		NAME OF CEMETERY OR CREMATORY <u>Zuaker Cemetery</u>		LOCATION (City, town, or county) <u>Galiville, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>4/25/57</u>		REGISTRAR'S SIGNATURE <u>J. J. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Galiville Md.</u>	

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased (Print or write full name)

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Date of death

9. Place of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial

18. Signature of interment

19. Signature of cremation

20. Signature of other

21. Signature of record

22. Signature of office

23. Signature of department

24. Signature of state

25. Signature of federal

26. Signature of international

27. Signature of universal

28. Signature of world

29. Signature of universe

30. Signature of everything

31. Signature of all

32. Signature of every

33. Signature of each

34. Signature of one

35. Signature of any

36. Signature of some

37. Signature of many

38. Signature of much

39. Signature of more

40. Signature of most

41. Signature of all

42. Signature of every

43. Signature of each

44. Signature of one

45. Signature of any

46. Signature of some

47. Signature of many

48. Signature of much

49. Signature of more

50. Signature of most

51. Signature of all

52. Signature of every

53. Signature of each

54. Signature of one

55. Signature of any

56. Signature of some

57. Signature of many

58. Signature of much

59. Signature of more

60. Signature of most

61. Signature of all

62. Signature of every

63. Signature of each

64. Signature of one

65. Signature of any

66. Signature of some

67. Signature of many

68. Signature of much

69. Signature of more

70. Signature of most

71. Signature of all

72. Signature of every

73. Signature of each

74. Signature of one

75. Signature of any

76. Signature of some

77. Signature of many

78. Signature of much

79. Signature of more

80. Signature of most

81. Signature of all

82. Signature of every

83. Signature of each

84. Signature of one

85. Signature of any

86. Signature of some

87. Signature of many

88. Signature of much

89. Signature of more

90. Signature of most

91. Signature of all

92. Signature of every

93. Signature of each

94. Signature of one

95. Signature of any

96. Signature of some

97. Signature of many

98. Signature of much

99. Signature of more

100. Signature of most

101. Signature of all

102. Signature of every

103. Signature of each

104. Signature of one

105. Signature of any

106. Signature of some

107. Signature of many

108. Signature of much

109. Signature of more

110. Signature of most

111. Signature of all

112. Signature of every

113. Signature of each

114. Signature of one

115. Signature of any

116. Signature of some

117. Signature of many

118. Signature of much

119. Signature of more

120. Signature of most

121. Signature of all

122. Signature of every

123. Signature of each

124. Signature of one

125. Signature of any

126. Signature of some

127. Signature of many

128. Signature of much

129. Signature of more

130. Signature of most

131. Signature of all

132. Signature of every

133. Signature of each

134. Signature of one

135. Signature of any

136. Signature of some

137. Signature of many

138. Signature of much

139. Signature of more

140. Signature of most

141. Signature of all

142. Signature of every

143. Signature of each

144. Signature of one

145. Signature of any

146. Signature of some

147. Signature of many

148. Signature of much

149. Signature of more

150. Signature of most

151. Signature of all

152. Signature of every

153. Signature of each

154. Signature of one

155. Signature of any

156. Signature of some

157. Signature of many

158. Signature of much

159. Signature of more

160. Signature of most

161. Signature of all

162. Signature of every

163. Signature of each

164. Signature of one

165. Signature of any

166. Signature of some

167. Signature of many

168. Signature of much

169. Signature of more

170. Signature of most

171. Signature of all

172. Signature of every

173. Signature of each

174. Signature of one

175. Signature of any

176. Signature of some

177. Signature of many

178. Signature of much

179. Signature of more

180. Signature of most

181. Signature of all

182. Signature of every

183. Signature of each

184. Signature of one

185. Signature of any

186. Signature of some

187. Signature of many

188. Signature of much

189. Signature of more

190. Signature of most

191. Signature of all

192. Signature of every

193. Signature of each

194. Signature of one

195. Signature of any

196. Signature of some

197. Signature of many

198. Signature of much

199. Signature of more

200. Signature of most

201. Signature of all

202. Signature of every

203. Signature of each

204. Signature of one

205. Signature of any

206. Signature of some

207. Signature of many

208. Signature of much

209. Signature of more

210. Signature of most

211. Signature of all

212. Signature of every

213. Signature of each

214. Signature of one

215. Signature of any

216. Signature of some

217. Signature of many

218. Signature of much

219. Signature of more

220. Signature of most

221. Signature of all

222. Signature of every

223. Signature of each

224. Signature of one

225. Signature of any

226. Signature of some

227. Signature of many

228. Signature of much

229. Signature of more

230. Signature of most

231. Signature of all

232. Signature of every

233. Signature of each

234. Signature of one

235. Signature of any

236. Signature of some

237. Signature of many

238. Signature of much

239. Signature of more

240. Signature of most

241. Signature of all

242. Signature of every

243. Signature of each

244. Signature of one

245. Signature of any

246. Signature of some

247. Signature of many

248. Signature of much

249. Signature of more

250. Signature of most

251. Signature of all

252. Signature of every

253. Signature of each

254. Signature of one

255. Signature of any

256. Signature of some

257. Signature of many

258. Signature of much

259. Signature of more

260. Signature of most

261. Signature of all

262. Signature of every

263. Signature of each

264. Signature of one

265. Signature of any

266. Signature of some

267. Signature of many

268. Signature of much

269. Signature of more

270. Signature of most

271. Signature of all

272. Signature of every

273. Signature of each

274. Signature of one

275. Signature of any

276. Signature of some

277. Signature of many

278. Signature of much

279. Signature of more

280. Signature of most

281. Signature of all

282. Signature of every

283. Signature of each

284. Signature of one

285. Signature of any

286. Signature of some

287. Signature of many

288. Signature of much

289. Signature of more

290. Signature of most

291. Signature of all

292. Signature of every

293. Signature of each

294. Signature of one

295. Signature of any

296. Signature of some

3624

CERTIFICATE OF DEATH

Reg. Dist. No. "L 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis md</i>				c. LENGTH OF STAY IN 1b <i>2 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>SUSAN</i> Middle <i>SMITH</i> Last <i>SMITH</i>				4. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>1957</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/6/51</i>	
9. AGE (In years last birthday) <i>5</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>SOUTH CAROLINA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>SMITH, CHARLES F</i>				14. MOTHER'S MAIDEN NAME <i>MARY DEBORAH NOVADEL</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MOTHER</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxia</i> <i>492X</i> DUE TO <i>aspiration pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>1/2 hour</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Post-op tonsillectomy</i>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>28 Apr</i> , 1957, to <i>29 Apr</i> , 1957, that I last saw the deceased alive on <i>29 Apr</i> , 1957, and that death occurred at <i>9 P</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>51 SOUTH GATE AVE</i> DATE SIGNED <i>L. L. Ochs</i>							
ACTUAL SIGNATURE <i>L. L. Ochs</i>		PHYSICIAN'S NAME (Type) <i>I. L. Ochs M.D.</i> <i>ANNAPOLIS, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-2-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Glen Burnie, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HOPPING FUNERAL HOME</i> ADDRESS <i>Annapolis, Md.</i>				24. REC'D BY REGISTRAR <i>MAY 2 1957</i> 24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 2 1957

BUREAU V. 3

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. DATE OF BIRTH [Faint text]		4. PLACE OF BIRTH [Faint text]	
5. MARITAL STATUS [Faint text]		6. OCCUPATION [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]	
9. SIGNATURE OF DECEASED [Faint text]		10. SIGNATURE OF WITNESS [Faint text]	
11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF CORONER [Faint text]	
13. SIGNATURE OF JURY [Faint text]		14. SIGNATURE OF JUDGE [Faint text]	
15. SIGNATURE OF CLERK [Faint text]		16. SIGNATURE OF NOTARY [Faint text]	
17. SIGNATURE OF [Faint text] [Faint text]		18. SIGNATURE OF [Faint text] [Faint text]	
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93. SIGNATURE OF [Faint text] [Faint text]		94. SIGNATURE OF [Faint text] [Faint text]	
95. SIGNATURE OF [Faint text] [Faint text]		96. SIGNATURE OF [Faint text] [Faint text]	
97. SIGNATURE OF [Faint text] [Faint text]		98. SIGNATURE OF [Faint text] [Faint text]	
99. SIGNATURE OF [Faint text] [Faint text]		100. SIGNATURE OF [Faint text] [Faint text]	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3680

CERTIFICATE OF DEATH

03659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 4 mos. 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 609 George Street			
3. NAME OF DECEASED (Type or print) First Betty Middle Spriggs Last Spriggs				4. DATE OF DEATH Month 4 Day 23 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
9. AGE (In years last birthday) 65? yrs.		IF UNDER 1 YEAR Months 4 Days 23 Hours 19 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not given		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		(If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12/17 , 19 56 , to 4/23 , 19 57 , that I last saw the deceased alive on 4/22 , 19 57 , and that death occurred at 7:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/23/57							
ACTUAL SIGNATURE [Signature] M.D. Crownsville, Md.				DATE SIGNED 4/23/57			
PHYSICIAN'S NAME (Type) L. Benedict							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		5-3-57		St. Johns Balto. Md.		Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS [Address]				24a. REC'D BY REGISTRAR DATE 5/6/57		24b. REGISTRAR'S SIGNATURE [Signature]	

BUREAU V. J.

MAY 7 1957

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03660

24

Reg. Dist. No.

3681

CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Md.</u> COUNTY <u>A-A-Co-</u>		CITY OR TOWN <u>Glen Burnie</u>		CITY OR TOWN <u>Glen Burnie</u>	
CITY OR TOWN <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>15 yrs</u>		STREET ADDRESS <u>#8 Georgia Ave. N.E.</u>		STREET ADDRESS <u>#8 Georgia Ave. N.E.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8 Georgia Ave</u>							
3. NAME OF DECEASED (First) <u>Louise</u> (Middle) <u>STAFFORD</u> (Last) <u>STAFFORD</u>				4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>14</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 31, 1885</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A-</u>	
13. FATHER'S NAME <u>Frederick Schnell</u>				14. MOTHER'S MAIDEN NAME <u>Mary (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Walter C. Stafford</u>		<u>Same as #2</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170X IMMEDIATE CAUSE (A) <u>Generalized Carcinomatosis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Oct 1, 1955</u> , to <u>present</u> , that I last saw the deceased alive on <u>Apr. 14, 1957</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph Taler</u>		ADDRESS (Street, city, town, state) <u>102 Baltimore-Annapolis Rd. N.E. Glen Burnie, Md.</u>		DATE SIGNED <u>Apr. 14, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 18, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cems</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. RECEIVED BY REGISTRAR <u>APR 17 1957</u>		REGISTRAR'S SIGNATURE <u>L. J. Dealby</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>T. J. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

CERTIFICATE OF DEATH

Reg. One, Vol.

ALL MARRIAGES MUST BE REGISTERED ON OCCASION

DATE OF DEATH
BY
PLACE

DATE OF DEATH
BY
PLACE

DATE OF DEATH

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DATE OF DEATH

BY

PLACE

NOT TO BE FILLED IN BY THE DEPARTMENT OF HEALTH
THIS CERTIFICATE IS TO BE FILLED IN BY THE DEPARTMENT OF HEALTH
ON THE DAY OF DEATH OR AS SOON THEREAFTER AS POSSIBLE
IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO
REGISTER ALL DEATHS WHICH OCCUR IN THE STATE
AND TO ISSUE THIS CERTIFICATE OF DEATH
TO THE PERSON OR PERSONS TO WHOM IT IS DUE
IT IS THE DUTY OF THE DEPARTMENT OF HEALTH
TO KEEP THIS CERTIFICATE OF DEATH
IN THE OFFICE OF THE DEPARTMENT OF HEALTH
UNTIL IT IS REQUIRED BY THE COURT
OR BY THE PERSON OR PERSONS TO WHOM IT IS DUE
IT IS THE DUTY OF THE DEPARTMENT OF HEALTH
TO DESTROY THIS CERTIFICATE OF DEATH
WHEN IT IS NO LONGER REQUIRED
BY THE COURT OR BY THE PERSON OR PERSONS
TO WHOM IT IS DUE

BUREAU V. S.

APR 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03661

3625

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>STREIF</u> Last <u>STREIF</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>30</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 19, 1905</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stanislaus Piasecki</u>		14. MOTHER'S MAIDEN NAME <u>Stella Urbanska</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Ernest Streif- Husband- Same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> <u>430.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bacterial endocarditis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>4 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u> </u> , to <u>4/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/30</u> , 19 <u>57</u> , and that death occurred at <u>1:38</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>5/2/57</u>			
ACTUAL SIGNATURE <u>John R. Hedeman</u> M.D.		PHYSICIAN'S NAME (Type) <u>John Hedeman MD</u> <u>90 Cathedral Street Annapolis Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 3, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG215 5-21-57 et

3626

CERTIFICATE OF DEATH

0366221

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>C. C. General Hosp.</u>				d. STREET ADDRESS <u>19512 East St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Thomas</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cole</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11-1-1903</u> 53 yrs.	
9. AGE (In years last birthday) <u>53</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u> Hours <u>54</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>			
13. FATHER'S NAME <u>Daniel Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Sachel Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Allen Thomas - Annapolis, Md.</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chemia</u> <u>443X</u> DUE TO <u>Arterio sclerotic hypertensive cardio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>vascular Disease</u> (c) <u>Grade III</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 1st, 1957</u> to <u>April 9, 1957</u> , that I last saw the deceased alive on <u>April 9, 1957</u> , and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richardson</u>				ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, MD.</u>			
DATE SIGNED <u>4/9/57</u>							
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>10 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>—</u>							

CERTIFICATE OF DEATH

1. Name of deceased: *James Thomas*
2. Date of death: *4-11-1953*
3. Place of death: *Home*
4. Cause of death: *Heart disease*
5. Physician: *Dr. J. H. Thomas*
6. Burial place: *St. James Cemetery*
7. Age: *45*
8. Sex: *Male*
9. Race: *White*
10. Marital status: *Married*
11. Occupation: *Teacher*
12. Date of birth: *4-11-1908*
13. Place of birth: *St. Louis, Mo.*
14. Date of death: *4-11-1953*
15. Place of death: *Home*
16. Cause of death: *Heart disease*
17. Physician: *Dr. J. H. Thomas*
18. Burial place: *St. James Cemetery*
19. Age: *45*
20. Sex: *Male*
21. Race: *White*
22. Marital status: *Married*
23. Occupation: *Teacher*
24. Date of birth: *4-11-1908*
25. Place of birth: *St. Louis, Mo.*

BUREAU V. 3

APR 10 1957

RECEIVED

26. Date of death: *4-11-1953*
27. Place of death: *Home*
28. Cause of death: *Heart disease*
29. Physician: *Dr. J. H. Thomas*
30. Burial place: *St. James Cemetery*
31. Age: *45*
32. Sex: *Male*
33. Race: *White*
34. Marital status: *Married*
35. Occupation: *Teacher*
36. Date of birth: *4-11-1908*
37. Place of birth: *St. Louis, Mo.*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03663

3627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>a a.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General</i>		d. STREET ADDRESS <i>1164 Eastport Terrace</i>	
3. NAME OF DECEASED (Type or print) First <i>Paul</i> Middle <i>E.</i> Last <i>Thompson</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 31-1915</i>
9. AGE (In years last birthday) <i>42</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Station Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY (Plant) <i>Filtration City</i>	
11. BIRTHPLACE (State or foreign country) <i>Stanton Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Susan G. Thompson</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9-11-56</i> , 19 <i>56</i> , to <i>4-5-57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4-1-57</i> , 19 <i>57</i> , and that death occurred at <i>7 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. T. Allen</i>		ADDRESS (Street, city or town, state) <i>6 L Crooked Rd</i>	
PHYSICIAN'S NAME (Type) <i>A T ALLEN</i>		DATE SIGNED <i>4-5-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-6-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hill Crest Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sins</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR <i>4/5/57</i>		24b. REGISTRAR'S SIGNATURE <i>Truesdell</i>	

3682

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Linthicum</i>		c. LENGTH OF STAY IN 1b <i>4 mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Smith Beach</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>202 Lane Ave</i>				d. STREET ADDRESS <i>1303 Lane Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Adolph G. Frost</i>				4. DATE OF DEATH Month <i>4</i> Day <i>30</i> Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 13, 1884</i>		9. AGE (In years last birthday) <i>73</i> yrs.	IF UNDER 1 YEAR Months <i>7</i> Days <i>15</i> Hours <i>57</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Supermarket</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Michael Frost</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Stice</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mr. Surrette A. Frost 202 Lane Ave</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral accident</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>chronic heart failure & embolization</i> DUE TO (c) <i>Arteriosclerosis & poss. malignancy</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	
20f. (City or town) <i>—</i>				20g. (County) <i>—</i>		20h. (State) <i>—</i>	
21. I certify that I attended the deceased from <i>1954</i> to <i>4.30</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4.30</i> , 19 <i>57</i> , and that death occurred at <i>5:17</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1802 W. Baltimore St. Balt.</i> DATE SIGNED <i>5-15</i>							
ACTUAL SIGNATURE <i>Stanley Ankudis</i> M.D.				PHYSICIAN'S NAME (Type) <i>STANLEY ANKUDIS</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>5/3/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>New Baltimore</i>		22d. LOCATION (City, town, or County) (State) <i>4300 Old Rd. Road</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howan Bow</i>				24a. REC'D BY REGISTRAR <i>May 8 57</i>		24b. REGISTRAR'S SIGNATURE <i>Overman</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3683

CERTIFICATE OF DEATH

Reg. Dist. No.

03665

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle Nathan Last Tucker		4. DATE OF DEATH Month April Day 17 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed Maintenance Man--Hotel Industry-		10b. KIND OF BUSINESS OR INDUSTRY Maryland.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ace Tucker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-16-1036A	
17. INFORMANT Mrs. Edna Hardesty-Bristol, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 14, 1957 , to 17, 1957 , that I last saw the deceased alive on 17, 1957 , and that death occurred at 2:28 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. B. Sasscer		DATE SIGNED 4/17/57	
PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.		ADDRESS (Street, city or town, state) Upper Marlboro, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/20/57.	22c. NAME OF CEMETERY OR CREMATORY Smithville Cemetery	22d. LOCATION (City, town, or county) (State) Smithville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Maryland		24a. REC'D BY REGISTRAR APR 22 1957	
ADDRESS Upper Marlboro, Maryland		24b. REGISTRAR'S SIGNATURE R. H. K. K. K.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF DEATH April 1, 1957	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
OCCUPATION Teacher		EDUCATION High School		MARRIAGE Married		SINGLE Single		DIVORCED Divorced	
DATE OF BIRTH March 15, 1912		PLACE OF BIRTH Baltimore		PARENTS John H. Harris, Mary E. Harris		SIBLINGS None		PREVIOUS ILLNESS None	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 12345		REGISTRATION NO. 67890		FILING NO. 11122	
SIGNATURE OF PHYSICIAN Dr. J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith		SIGNATURE OF DECEASED James H. Harris		SIGNATURE OF NEXT OF KIN Mrs. J. H. Harris		SIGNATURE OF WITNESS J. H. Smith	

BUREAU V. 3

APR 22 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3628

Item 9 Film G215 5-15-57 et

CERTIFICATE OF DEATH

03667 21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>110 Smithville at</i>	
3. NAME OF DECEASED (Type or print) <i>William</i> First <i>Weston</i> Middle <i>Weston</i> Last		4. DATE OF DEATH <i>Apr. 21</i> 19 <i>57</i> Month Day Year	
5. SEX <i>male</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 4 1881</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S.N. Academy</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Mt Vernon AA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Phillip Weston</i>		14. MOTHER'S MAIDEN NAME <i>Becelia Weston</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Sold. Weston</i> Address <i>110 Smithville at</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Prostate gland</i> DUE TO <i>177X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 6</i> , 19 <i>55</i> , to <i>April 3</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4</i> <i>2</i> , 19 <i>57</i> , and that death occurred at <i>12:30 p</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodore H. Johnson M.D.</i>		ADDRESS (Street, city or town, state) <i>37 Calvert Street, Annapolis, Md.</i>	
PHYSICIAN'S NAME (Type) <i>DR. Theodore H. Johnson, Jr.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Apr. 26 1957</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Bowlers</i>		22d. LOCATION (City, town, or county) (State) <i>Best Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i> ADDRESS <i>Annapolis</i>		24a. REC'D BY REGISTRAR <i>APR 25 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>Am. J. French</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		M		W		APR 3, 1957	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		LOCALITY	
BALTIMORE, MD		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		BALTIMORE, MD	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		DATE OF BIRTH	
CLERK		HIGH SCHOOL		METHODIST		MARRIED		APR 1, 1912	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

Government of Rochester, New York

240

BUREAU V. S.

APR 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03668

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Michigan b. COUNTY Cass			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade, Md		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dawagiac 59X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Quarters 4326				d. STREET ADDRESS 601 Main St.			
3. NAME OF DECEASED (Type or print) First HARRY Middle HUNTINGTON Last WHITELEY				4. DATE OF DEATH Month APRIL Day 25 Year 1957			
5. SEX M	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 May 1882		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired newspaper man		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Whiteley			14. MOTHER'S MAIDEN NAME Luella Piper				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 366-05-8874		17. INFORMANT Col Hal S. Whiteley, Ft George G. Meade Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) GUSTAVE H. FAUBERT, MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 4-26-57		22c. NAME OF CEMETERY OR CREMATORY Mason Cemetery		22d. LOCATION (City, town, or county) (State) Mason, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. RECEIVED BY REGISTRAR APR 29 1957 24b. REGISTRAR'S SIGNATURE Lt. Wm. Saylor			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

APR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03669

3629

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. NAVAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>ANNAPOLIS, MARYLAND</u>							
3. NAME OF DECEASED (Type or print) First <u>Eric</u> Middle <u>Kent</u> Last <u>WHYTE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 April 1957</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Kent Eugene WHYTE</u>				14. MOTHER'S MAIDEN NAME <u>Joanne Ardelles ANDERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>U.S. Naval Hospital, Annapolis, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage - Multiple</u> <u>7600</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>26 April</u> , 19 <u>57</u> , to <u>27 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>27 April</u> , 19 <u>57</u> , and that death occurred at <u>6:20 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>27 April 1957</u> ACTUAL SIGNATURE <u>Richard D. Sheehan</u> PHYSICIAN'S NAME (Type) <u>Richard D. SHEEHAN, LT MC USNR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>4-29-57</u>		<u>NAVAL CEMETERY</u>		<u>ANNAPOLIS MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor, Sons</u>				24a. REC'D BY REGISTRAR <u>4/29/57</u>			
ADDRESS <u>Annapolis, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
FIREARM WOUND TO THE CHEST		SUICIDE		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		ONE		ONE		ONE	
PHYSICIAN'S SIGNATURE		PHYSICIAN'S NAME		PHYSICIAN'S ADDRESS		PHYSICIAN'S CITY		PHYSICIAN'S STATE		PHYSICIAN'S COUNTRY		PHYSICIAN'S DATE		PHYSICIAN'S PLACE		PHYSICIAN'S CITY	
[Signature]		DR. JAMES EARL RAY		[Address]		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS	
CORONER'S SIGNATURE		CORONER'S NAME		CORONER'S ADDRESS		CORONER'S CITY		CORONER'S STATE		CORONER'S COUNTRY		CORONER'S DATE		CORONER'S PLACE		CORONER'S CITY	
[Signature]		DR. JAMES EARL RAY		[Address]		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS	

BUREAU V. 2

APR 30 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3630

CERTIFICATE OF DEATH

Reg. Dist. No.

03670

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Paul</u> First <u>B</u> Middle <u>WIER SR.</u> Last				4. DATE OF DEATH <u>April</u> Month <u>20</u> Day <u>1957</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/1889</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY Academy</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOSEPH N. WIER</u>				14. MOTHER'S MAIDEN NAME <u>SARAH WOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> If yes, give war or dates of service				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>ROBERT B. WIER</u> Address <u># 2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mistake carcinoma of pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>157X</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1 Coronary artery disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>20 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19 April</u> , 19 <u>57</u> , and that death occurred at <u>7:45</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>4/20/57</u>							
ACTUAL SIGNATURE <u>John H. Hrdeman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> ADDRESS <u>Annapolis Md.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>4/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

BUREAU V. S.

APR 23 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3631

CERTIFICATE OF DEATH

Reg. Dist. No.

03671

1. PLACE OF DEATH o. COUNTY <i>Andover</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Ind</i> b. COUNTY <i>Ann Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>General Ann Arundel Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles E. Willet</i>				4. DATE OF DEATH Month Day Year <i>April 9, 1957</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 16, 1869</i>	
9. AGE (In years last birthday) yrs. <i>87</i>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cigar Maker</i>		11. BIRTHPLACE (State or foreign country) <i>Adams Co., Penna.</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>		11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Cyrus L. Willet</i>	
14. MOTHER'S MAIDEN NAME <i>Margaret Hornberger</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>Howard Willet 307 Monterey Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL VASCULAR ACCIDENT</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>331X</i> (b) <i>CEREBRAL ARTERIOSCLEROSIS</i> DUE TO (c) <i>ARTERIOSCLEROSIS, GENERALIZED</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>FRACTURED LEFT HUMERUS</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 DAYS</i> <i>6 MOS.</i> <i>UNKNOWN</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>BECAME DIZZY, FELL TO GROUND, STRIKING SHOULDER</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>10</i> p. m. <i>4/6 1957</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>HOME</i>				20f. (City or town) <i>ANNAPOLIS</i> (County) <i>ANNE ARUNDEL MD</i> (State)			
21. I certify that I attended the deceased from <i>4/6</i> , 1957, to <i>4/9</i> , 1957, that I last saw the deceased alive on <i>4/9</i> , 1957, and that death occurred at <i>11 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edward S. Beck</i> M.D.				ADDRESS (Street, city or town, state) <i>41 Southgate Ave</i> DATE SIGNED <i>4/9/57</i>			
PHYSICIAN'S NAME (Type) <i>EDWARD S. BECK</i>				ANNAPOLIS, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried April 12, 1957</i>				22b. DATE THEREOF <i>April 12, 1957</i>			
22c. NAME OF CEMETERY OR CREMATORY <i>Green Ridge</i>				22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Ind</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Foring Byers</i> ADDRESS <i>5025 PK Plaza</i>				24a. REC'D BY REGISTRAR <i>DATE 4-28-57</i>			
24b. REGISTRAR'S SIGNATURE <i>Ann J. French</i>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN		16. SIGNATURE OF BURIAL OFFICIAL		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CHURCH		19. SIGNATURE OF CEMETERY		20. SIGNATURE OF OTHER	

BUREAU V. S.

APR 30 1957

RECEIVED

3685

CERTIFICATE OF DEATH

036728

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 30 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goshen 15X12	
		d. STREET ADDRESS Gedesberg, Md., Route #2	
3. NAME OF DECEASED (Type or print) First Middle Last Bradley Warefield Wilson		4. DATE OF DEATH Month Day Year April 19 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 18, 1900
9. AGE (In years lost birthday) yrs. 56		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland, U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Wilson		14. MOTHER'S MAIDEN NAME Victoria G. Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Wellington James Wilson, Goshen, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Colon. 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Acute Urinary Retention, Dehydration & Malnutrition.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 19th, 1957 , to April 19th, 1957 , that I last saw the deceased alive on April 19th, 1957 , and that death occurred at 4.15P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Ludwig Benedict, M.D.		M.D. Crownsville State Hospital, April 19th, 1957	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M.D.		Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	4/23/57	Brookgrove	Laytonsville Ind
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Anand		ADDRESS Rockville Md	
24a. REC'D BY REGISTRAR APR 29 1957		24b. REGISTRAR'S SIGNATURE H. M. Joyce	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VICTIM AND STATE DEPARTMENT OF HEALTH—SALTWATER, FL.

BUREAU

APR 29 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 14 Film G211 4-22-57 et
3686
CERTIFICATE OF DEATH

03673

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover RFD		c. LENGTH OF STAY IN 1b 32 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover RFD		d. STREET ADDRESS Stoney Run Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CARRIE MARY WOLFE		4. DATE OF DEATH Month Day Year April 9, 1957		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1887		9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (ret.)		11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Sevier		14. MOTHER'S MAIDEN NAME Betty Redmiles		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Mr. Lewis W. Wolfe		Address Same As #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMMORRAGE DUE TO (b) HYPERTENSION DUE TO (c) ARTERIO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 DAY					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 8 APRIL, 1957 to 9 APRIL, 1957 , that I last saw the deceased alive on 8 APRIL, 1957 , and that death occurred at 11:40 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) George E. Grollean, M.D. 5608 MAIN ST ELK RIDGE, MD 21141		DATE SIGNED MO		ACTUAL SIGNATURE George E. Grollean		FURNAL DIRECTOR'S NAME (Type) GEORGE E. GROLLEAN		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 12/57		22c. NAME OF CEMETERY OR CREMATORY Nickols Mem. Ch. Cem. Odenton, Maryland		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Richard S. Sipe		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE APR 15 1957		24b. REGISTRAR'S SIGNATURE R. J. Redmiles													

APR 15 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03674

3632 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis		LENGTH OF STAY (In this place) 12 days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Seat Pleasant 16x22			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescent Home 1312 West Street				STREET ADDRESS (If rural give location) 524--68th Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) IRA (Middle) ORVAL (Last) WORTHINGTON				(Month) April (Day) 7th (Year) 1957			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 28th, 1881	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garbenter (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Fannetsburg, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Worthington				14. MOTHER'S MAIDEN NAME Elizabeth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS 4615 Howe Ave. SE Ira C. Worthington, Bradbury Park, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
4220 IMMEDIATE CAUSE (A) Anterosecaratic Heart Disease						10 yrs.	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 26 MAR., 1957, to 7 APR., 1957, that I last saw the deceased alive on 6 APR., 1957, and that death occurred at 12:10 P.M. from the causes and on the date stated above.							
SIGNATURE Edward L. Beck				M.D. 4 Southgate Ave Annapolis		DATE SIGNED 4/7/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/10/1957		NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co. Md.	
24. RECEIVED BY REGISTRAR APR 9 1957		REGISTRAR'S SIGNATURE Wm. J. French		25. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS 517--11th St. S. E. Washington, D.C.	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

For the purpose of recording the death of a person, the following information is required to be furnished by the attending physician or the person in charge of the funeral home.

<p>NAME OF DECEASED JOHN J. SMITH</p> <p>AGE 45</p> <p>SEX Male</p> <p>RACE White</p> <p>DATE OF BIRTH Jan 15, 1900</p> <p>PLACE OF BIRTH Baltimore, Md.</p> <p>EDUCATION High School</p> <p>OCCUPATION Engineer</p> <p>RELIGION Catholic</p> <p>Usual Residence 1234 Main St., Baltimore, Md.</p> <p>Present Residence 1234 Main St., Baltimore, Md.</p> <p>Married () Single () Widowed () Divorced ()</p> <p>Spouse's Name John J. Smith</p> <p>Spouse's Date of Birth Jan 15, 1900</p> <p>Spouse's Place of Birth Baltimore, Md.</p> <p>Spouse's Education High School</p> <p>Spouse's Occupation Engineer</p> <p>Spouse's Religion Catholic</p> <p>Spouse's Usual Residence 1234 Main St., Baltimore, Md.</p> <p>Spouse's Present Residence 1234 Main St., Baltimore, Md.</p> <p>Spouse's Married () Single () Widowed () Divorced ()</p>	<p>DATE OF DEATH Apr 9, 1945</p> <p>PLACE OF DEATH Home</p> <p>CAUSE OF DEATH Heart Disease</p> <p>IMMEDIATE CAUSE Myocardial Infarction</p> <p>PREVAILING DISEASE Coronary Artery Disease</p> <p>PREVAILING SYMPTOMS Chest Pain, Shortness of Breath</p> <p>PREVAILING SIGNS Palpitations, Swelling of Feet</p> <p>PREVAILING TREATMENT Medication, Rest</p> <p>PREVAILING PROGNOSIS Uncertain</p> <p>PREVAILING MEDICAL HISTORY None</p> <p>PREVAILING SOCIAL HISTORY None</p> <p>PREVAILING PERSONAL HISTORY None</p> <p>PREVAILING FAMILY HISTORY None</p> <p>PREVAILING RACE White</p> <p>PREVAILING SEX Male</p> <p>PREVAILING AGE 45</p> <p>PREVAILING PLACE OF BIRTH Baltimore, Md.</p> <p>PREVAILING EDUCATION High School</p> <p>PREVAILING OCCUPATION Engineer</p> <p>PREVAILING RELIGION Catholic</p> <p>PREVAILING Usual Residence 1234 Main St., Baltimore, Md.</p> <p>PREVAILING Present Residence 1234 Main St., Baltimore, Md.</p> <p>PREVAILING Married () Single () Widowed () Divorced ()</p> <p>PREVAILING Spouse's Name John J. Smith</p> <p>PREVAILING Spouse's Date of Birth Jan 15, 1900</p> <p>PREVAILING Spouse's Place of Birth Baltimore, Md.</p> <p>PREVAILING Spouse's Education High School</p> <p>PREVAILING Spouse's Occupation Engineer</p> <p>PREVAILING Spouse's Religion Catholic</p> <p>PREVAILING Spouse's Usual Residence 1234 Main St., Baltimore, Md.</p> <p>PREVAILING Spouse's Present Residence 1234 Main St., Baltimore, Md.</p> <p>PREVAILING Spouse's Married () Single () Widowed () Divorced ()</p>	<p>NAME OF PHYSICIAN Dr. J. H. Smith</p> <p>ADDRESS 1234 Main St., Baltimore, Md.</p> <p>DATE OF EXAMINATION Apr 9, 1945</p> <p>PLACE OF EXAMINATION Home</p> <p>CAUSE OF DEATH Heart Disease</p> <p>IMMEDIATE CAUSE Myocardial Infarction</p> <p>PREVAILING DISEASE Coronary Artery Disease</p> <p>PREVAILING SYMPTOMS Chest Pain, Shortness of Breath</p> <p>PREVAILING SIGNS Palpitations, Swelling of Feet</p> <p>PREVAILING TREATMENT Medication, Rest</p> <p>PREVAILING PROGNOSIS Uncertain</p> <p>PREVAILING MEDICAL HISTORY None</p> <p>PREVAILING SOCIAL HISTORY None</p> <p>PREVAILING PERSONAL HISTORY None</p> <p>PREVAILING FAMILY HISTORY None</p> <p>PREVAILING RACE White</p> <p>PREVAILING SEX Male</p> <p>PREVAILING AGE 45</p> <p>PREVAILING PLACE OF BIRTH Baltimore, Md.</p> <p>PREVAILING EDUCATION High School</p> <p>PREVAILING OCCUPATION Engineer</p> <p>PREVAILING RELIGION Catholic</p> <p>PREVAILING Usual Residence 1234 Main St., Baltimore, Md.</p> <p>PREVAILING Present Residence 1234 Main St., Baltimore, Md.</p> <p>PREVAILING Married () Single () Widowed () Divorced ()</p> <p>PREVAILING Spouse's Name John J. Smith</p> <p>PREVAILING Spouse's Date of Birth Jan 15, 1900</p> <p>PREVAILING Spouse's Place of Birth Baltimore, Md.</p> <p>PREVAILING Spouse's Education High School</p> <p>PREVAILING Spouse's Occupation Engineer</p> <p>PREVAILING Spouse's Religion Catholic</p> <p>PREVAILING Spouse's Usual Residence 1234 Main St., Baltimore, Md.</p> <p>PREVAILING Spouse's Present Residence 1234 Main St., Baltimore, Md.</p> <p>PREVAILING Spouse's Married () Single () Widowed () Divorced ()</p>	<p>NAME OF FUNERAL HOME John J. Smith</p> <p>ADDRESS 1234 Main St., Baltimore, Md.</p> <p>DATE OF EXAMINATION Apr 9, 1945</p> <p>PLACE OF EXAMINATION Home</p> <p>CAUSE OF DEATH Heart Disease</p> <p>IMMEDIATE CAUSE Myocardial Infarction</p> <p>PREVAILING DISEASE Coronary Artery Disease</p> <p>PREVAILING SYMPTOMS Chest Pain, Shortness of Breath</p> <p>PREVAILING SIGNS Palpitations, Swelling of Feet</p> <p>PREVAILING TREATMENT Medication, Rest</p> <p>PREVAILING PROGNOSIS Uncertain</p> <p>PREVAILING MEDICAL HISTORY None</p> <p>PREVAILING SOCIAL HISTORY None</p> <p>PREVAILING PERSONAL HISTORY None</p> <p>PREVAILING FAMILY HISTORY None</p> <p>PREVAILING RACE White</p> <p>PREVAILING SEX Male</p> <p>PREVAILING AGE 45</p> <p>PREVAILING PLACE OF BIRTH Baltimore, Md.</p> <p>PREVAILING EDUCATION High School</p> <p>PREVAILING OCCUPATION Engineer</p> <p>PREVAILING RELIGION Catholic</p> <p>PREVAILING Usual Residence 1234 Main St., Baltimore, Md.</p> <p>PREVAILING Present Residence 1234 Main St., Baltimore, Md.</p> <p>PREVAILING Married () Single () Widowed () Divorced ()</p> <p>PREVAILING Spouse's Name John J. Smith</p> <p>PREVAILING Spouse's Date of Birth Jan 15, 1900</p> <p>PREVAILING Spouse's Place of Birth Baltimore, Md.</p> <p>PREVAILING Spouse's Education High School</p> <p>PREVAILING Spouse's Occupation Engineer</p> <p>PREVAILING Spouse's Religion Catholic</p> <p>PREVAILING Spouse's Usual Residence 1234 Main St., Baltimore, Md.</p> <p>PREVAILING Spouse's Present Residence 1234 Main St., Baltimore, Md.</p> <p>PREVAILING Spouse's Married () Single () Widowed () Divorced ()</p>
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RECEIVED

BUREAU V. S.

APR 9 1945

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3687
CERTIFICATE OF DEATH

03675

Reg. Dist. No.

24

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1213 Montgomery Dreive		d. STREET ADDRESS 1213 Montgomery Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Kathleen Middle Warner Last Wroe		4. DATE OF DEATH Month 4 Day 1 Year 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1894
9. AGE (In years lost by thdy) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker		10b. KIND OF BUSINESS OR INDUSTRY Goodwill Industry	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Warner		14. MOTHER'S MAIDEN NAME Martha Eunice Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 417-18-3626A	
17. INFORMANT William C. Wroe, same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lung to Metastasis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-25-57 , 19 57 , to 3-25 , 19 57 , that I last saw the deceased alive on 3-25-57 , 19 57 , and that death occurred at 12:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. McDonald MD		ADDRESS (Street, city or town/ state) 204 Ocean Hwy	
PHYSICIAN'S NAME (Type) Glen Burnie MD		DATE SIGNED 2 J. S. S. S.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/57	
22c. NAME OF CEMETERY OR CREMATORY All Saints		22d. LOCATION (City, town, or county) (State) Reisterstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Kirkley		ADDRESS Hopping & Kirkley, Glen Burnie, Md.	
24a. REC'D BY REGISTRAR APR 4 1957		24b. REGISTRAR'S SIGNATURE L. J. S. S.	

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. WILSON		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1910-03-15		PLACE OF BIRTH Baltimore, Md.	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several weeks		PLACE OF DEATH Home	
DATE OF DEATH 1957-04-10		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home		OCCUPATION Engineer		EDUCATION High School		MARRIAGE Married	
NAME OF DECEASED JOHN J. WILSON		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1910-03-15		PLACE OF BIRTH Baltimore, Md.	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several weeks		PLACE OF DEATH Home	
DATE OF DEATH 1957-04-10		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home		OCCUPATION Engineer		EDUCATION High School		MARRIAGE Married	

BUREAU W. 81

APR 4 1957

RECEIVED